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**Staff and service users' evaluations of therapeutic principles at
a High Secure Learning Disability Therapeutic Community
(LDTC)**

Georgina Capone

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Abstract

Background: Growing evidence has been provided on the efficacy of Democratic Therapeutic Community (DTC) treatment in forensic LD populations (known as learning disability therapeutic communities, LDTC) in the form of reduced violence, personality pathology and interpersonal difficulties. Recently, the LDTC model has been introduced within a high secure setting at one of three high secure hospitals in the U.K., for males with a dual diagnosis of mild LD and PD, and produced equally successful results. While a number of outcome studies exist, on-going difficulties have remained in regard to applying a post-positivist approach to research design of Therapeutic Communities (TCs) as the approach fails to capture its matrix of interrelated treatment components. Consequently, there has been a call for investigation of processes within DTCs to identify important treatment mechanisms that support therapeutic change. While Haigh (2013) has updated the theoretical background on DTCs via formulating 'quintessential principles' within a given therapeutic environment the principles have not been empirically validated within a TC setting.

Study aims: To explore service user and staff members' evaluations of the quintessence principles as outlined by Haigh (2013) and identify whether any further important principles exist within the social climate of the LDTC that were not captured by current TC theory.

Design: A single case study design was employed, with the 'case' being defined as the LDTC based at one of three high secure hospitals in the U.K. A qualitative approach was employed within the case study to enable initial analysis of TC members' experience of therapeutic principles, any additional principles and to also permit identification of any shared experiences.

The results of the qualitative analysis were used to develop a set of statements that can be used by future research to determine the importance of existing TC principles and additional elements identified in qualitative findings to TC members.

Method: A qualitative approach was employed to enable analysis of TC members' experience and evaluation of therapeutic principles in addition to identification of shared experiences. Data were collected via semi-structured interviews with 12 participants (6 staff members and 6 service users). The interview transcripts were initially analysed via deductive content analysis (Mayring, 2001) in order to identify whether Haigh's (2013) quintessence principles were evident in the LDTC. Inductive thematic analysis (Braun & Clarke, 2006) was then performed on remaining data, which also involved completion of saliency analysis (Buetow, 2010) in the final stage to justify selection of themes and ensure identification of codes that did not recur but remained important to the research questions posed.

Results:

The deductive content analysis identified all five quintessence principles were experienced in the LDTC environment by staff and service users. Some limits to the principle of 'agency' were highlighted, with specific reference to difficulties implementing a flattened hierarchy in a forensic setting. Additional themes were identified via inductive thematic analysis and a saliency analysis indicated the following themes as both important and recurrent; security and risk, responsiveness, trust, more physical freedom. Further themes that were identified as important but not recurrent within the saliency analysis included: staff fit with LDTC, moving on, being reflective.

The theme of security and risk was specifically related to the context of the LDTC functioning in a high secure environment and 'trust' was understood to fall within Haigh's (2013) conceptualization of the containment quintessence principle.

While the remaining themes may not primarily contribute to the experience of secondary emotional development outlined by Haigh's (2013) five quintessence principles they remain important considerations within therapeutic environments in light of their role in facilitating enactment of TC principles within secure environments, such as the LDTC.

Conclusions: This is the first research paper that has attempted to test whether Haigh's (2013) quintessence principles are evident within a given therapeutic community. The single case study provides empirical evidence for the quintessence principles in a novel TC setting along with further elements in the environment that help support implementation of quintessence principles. Fundamentally, the study suggests important recommendations for future research.

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Statement of Contribution

As the lead researcher I was responsible for the research design, the ethical applications, writing the literature review, and for the collection and analysis of data.

Dr Thomas Schroder (Research Tutor) contributed greatly to the research design, gave support with ethical issues in data collection as well as critically appraising drafts.

Dr Nima Moghaddam (Research Tutor) provided extremely valuable support and guidance during research meetings and helped with preparation for the viva.

Dr Simon Clarke (Research Tutor) also contributed to the research design, supported with the implementation of the study.

Dr Louise Braham (Field Supervisor) oversaw the planning and implementation of the study and in particular assisted with ethical approval and recruitment, as well as critically appraising drafts and giving many hours to the analysis.

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Glossary

CAT	Cognitive Analytic Therapy
CBT	Cognitive Behavioural Therapy
CCQI	College Centre for Quality Improvement
DBT	Dialectical Behaviour Therapy
DH	Department of Health
DTC	Democratic Therapeutic Community
EE	Enabling Environment
IA	Intellectual Ability
LDTC	Learning Disability Therapeutic Community
MBT	Mentalisation Based Therapy
NHS	National Health Service
NICE	National Institute of Clinical Excellence
NOMS	National Offender Management Service
PD	Personality Disorder
PIE	Psychologically Informed Environment
PIPE	Psychologically Informed Planned Environment
RCOP	Royal College of Psychiatrists
SPSS	Statistical Package for the Social Sciences
TAU	Treatment As Usual
TC	Therapeutic Community

Journal article and extended paper – preamble

The following article has been prepared for the 'International Journal of Therapeutic Communities'. Guidelines for submission to this periodical are included as Appendix U. It is assumed, due to the nature of the journal, that readers will have a detailed knowledge of therapeutic communities.

Word counts for this thesis are:

Journal Article: 36 pages with 9383 words, including tables and references (8000 without - please refer to Appendix V for confirmation from editor allowing extended word count)

Extended paper: 31825 words, not including tables, references or appendices.

Total word count: 52864 words.

Journal paper

Perceptions of therapeutic principles within a therapeutic community

Abstract

Purpose: This study aimed to explore staff and service users' perceptions of therapeutic principles within a unique male high secure learning disability therapeutic community (LDTC).

Design/methodology/approach: A qualitative approach was adopted using deductive content analysis (Mayring, 2001) and inductive thematic analysis (Braun & Clarke, 2006). Twelve participants took part in a semi-structured interview to explore their perceptions of Haigh's (2013) quintessence principles and any further additional therapeutic features in the environment not captured by the theory.

Findings: All five quintessence principles were identified in the LDTC environment. Some limits to the principle of 'agency' were highlighted, with specific reference to difficulties implementing a flattened hierarchy in a forensic setting. Additional therapeutic features were identified including; security and risk, responsivity, and more physical freedom which appear to aid implementation of the quintessence principles.

Research limitations/implications: The study was performed within a single case study design. Therefore results remain specific to this LDTC. However, the finding of these principles in such a unique setting may indicate Haigh's (2013) quintessence principles are evident in other Therapeutic Community (TC) environments.

Originality/value: This is the first research paper that has attempted to test whether Haigh's (2013) quintessence principles are evident within a given therapeutic community. The research provides empirical evidence for the quintessence principles in a novel TC setting and suggests recommendations for future research.

Keywords: *personality disorder, learning disability, therapeutic communities, forensic, secure.*

Introduction

The diagnosis of personality disorder (PD) within learning disability (LD) populations is prevalent within forensic settings (Blackburn, Logan, Donnelly & Renwick, 2003) and associated with placements in higher security settings, serious and repeated offending and poorer long-term outcomes (Alexander, Crouch, Halstead & Piachaud, 2006; Torr, 2008). Consequently, effective treatments are important for individuals and wider society.

Democratic Therapeutic Communities (DTCs) have been commonly implemented in the treatment of personality disorder (PD) in non-LD populations (Rutter & Tyrer, 2003), and recently LD populations (Taylor, Crowther & Bryant, 2015). A DTC is defined as a 'living-learning situation' whereby, 'difficulties a member has experienced in relations with others outside are re-experienced and reenacted, with regular opportunities...to examine and learn from these difficulties' (Kennard, 2004: 296). DTCs are most usefully understood as a treatment modality (i.e. integrating a range of psychological and/or pharmacological approaches) as opposed to a specific treatment method itself (Kennard, 1998).

Literature on treatment of offenders with both an LD and PD remains limited, largely as a result of 'diagnostic overshadowing' and difficulty differentiating between symptoms of LD and PD leading to under diagnosis (Taylor & Morrissey, 2012). Research on treatment for offenders with LD has indicated beneficial outcomes from adapted talking therapies, such as Cognitive Behavioural Therapy (CBT) and Dialectical Behaviour Therapy (DBT), with some case report evidence in existence for one to one psychodynamic therapy (Taylor & Morrissey, 2012).

Alternatively, growing evidence has been provided on the efficacy of DTC treatment in forensic LD populations (known as learning disability therapeutic communities, LDTC) in the form of reduced violence, personality pathology and interpersonal difficulties (Miles, 1969; Taylor, Crowther & Bryant, 2015).

The use of TCs within a learning disability population stems back to the 1940's where 'intentional communities' were first initiated (Kennard, 2004; Taylor, Crowther & Bryant, 2015). These communities were developed specifically for an LD population, and most commonly known as the 'Camphill Communities'. Based within the community, the aim of the communities was to provide of sense of belonging for individuals often marginalised by wider society. This was accomplished via incorporation of values from traditions such as the 'Christian Mission' and 'Philanthropy' to provide a lifelong residential environment for individuals with LD, as opposed to operating as hospital or community based treatment programs (Haigh & Lees, 2008). A number of core TC elements were adopted within community practice, including emphasis on equal status and the healing value of relationships. However, use of the psychodynamic model and analysis of social interaction was limited. Instead a particular focus was placed on practical work, as opposed to verbal exchange (Kennard, 2004).

Recently, the LDTC model has been introduced within a high secure setting at one of three high secure hospitals in the U.K. for males with a dual diagnosis of mild LD and PD, and produced equally successful results – reduced PD pathology, relational difficulties and incidents of physical aggression (Morrissey & Taylor, 2014). This is currently the only LDTC in existence within a high secure hospital.

Currently, treatment efficacy is generally evaluated against the favoured 'gold standard' form of research, such as RCTs (Haigh, 2005). However, a number of difficulties in generating 'gold standard' evidence for DTCs have been encountered; absence or reduced time of follow up, attrition, heterogeneity of outcome measures and patient population, participant selection and randomization, and establishing a suitable control group (see Capone, Schroder, Clarke & Braham, 2016; Lees, Manning & Rawlings, 1999; Warren et al., 2003).

The individualised nature of treatment has also limited measurement and standardization (Pearce & Autrique, 2010). As such, the limited 'gold standard' evidence base for DTCs compared to other developing psychotherapy treatments for PD, such as Cognitive Behaviour Therapy (CBT) and Dialectical Behaviour Therapy (DBT) (Antisocial PD – NICE [National Institute for Clinical Excellence], 2009; Borderline PD - NICE, 2010) has prevented its inclusion within treatment recommendations (Pearce & Autrique, 2010).

The number of issues arising from application of randomized controlled trial methodology suggests a post positivist approach to research design is incongruent with the complex nature of a DTC and consequently fails to capture its matrix of interrelated treatment components (Haigh, 2014). Some authors have therefore called for investigation of processes within DTCs to identify important treatment mechanisms that support therapeutic change (Aslan & Yates, 2015; Magor-Blatch et al., 2014; Veale et al., 2014). Investigation of the lived experiences of those who comprise the community (service users and staff members) could be of particular importance in undertaking this research endeavour (Veale et al., 2014).

A number of theoretical schools – sociological, systemic and psychological, have informed development and functioning of therapeutic environments more generally (Haigh, 2015).

For example, Rudolph Moos (1976) conducted extensive work into the personality of social environments and the processes and mechanisms within them that support change. Emphasis is placed on the physical structure of social environments. Increased physical space within a given setting is said to facilitate social and recreational activities, leading to increased cohesion amongst individuals and attraction of staff and residents with increased interpersonal skills who promote a sense of comfort and cohesion (Moos, 2012).

Practices central to TCs have also been understood in regard to psychoanalytic theories, such as Erikson's (1998) stages of psychosocial development and Mahler's (1968) separation-deindividuation theory of child development. Erikson's theory suggests a healthy developing individual is required to pass through eight stages from infancy to late adulthood. Passing through these stages begins at birth but unfold according to an individual's environmental and cultural upbringing.

Margaret Mahler (1968) suggested individuals navigate a 'separation-individuation' deficit from birth involving initial connection with one's surrounding environment before separating from attachment figures to develop a sense of self and identity over the first few years of life. The three stages (hatching, practising and rapprochement) have been applied to understand individual experiences in group therapy (Fried, 1970).

While a number of theories have been specifically developed to delineate core features within DTCs, these accounts have adopted a more generic perspective. Rapoport (1960) identified four principles to describe the core elements of a TC environment leading to the development of therapeutic relationships via ethnographic research at the Henderson Hospital. Four core principles were identified to describe the main elements of a TC environment: Democratisation, Communalism, Permissiveness, and Reality confrontation (Rapoport, 1960). These principles were solely derived from the perspectives of staff members within the hospital (Debaere et al. 2016).

Haigh (2013) provided an update of the above principles, utilising his own clinical experiences and linking this to psychoanalytic and attachment theory. The clinical utility of Rapoport's (1960) themes was extended, connecting the above external experiences to psychological processes experienced by individuals. A developmental model was advocated, whereby individuals are thought to progress through five key conditions: 'attachment (belonging), containment, communication, inclusion, and agency' (Haigh, 2013, p. 6). In combination, these elements are hypothesised to provide the basis for emotional development leading to 'healthy personality formation' (Haigh, 2013, p. 6).

Neither Haigh's (2013) or Rapoport's (1960) theories has been subject to empirical verification in either secure or non-secure settings for individuals with diagnoses of learning disabilities and personality disorder. Secure environments in particular come with their own set of challenges. As security and risk often remains on the forefront of the staff team's agenda, staff and patient relationships can become fractured as service users are restricted in a number of ways (Polden, 2010). For example, limited physical movement and established cultures discouraging contact between service users and staff (Polden, 2010) or being denied opportunities to address offence related factors on the basis of their disability (Taylor, 2010).

Within forensic TCs specifically, TC principles have been adapted to accommodate requirements of discipline and control (Rawlings, 1998). For example, the principle of agency is restricted so that service users can make decisions about the community without compromising the rules of the host institution. Individuals with an LD have been described to face further discriminatory experiences while in inpatient (NHS ENGLAND, 2015) and secure environments. Individuals with an LD can lack the capacity to manage or think about their feelings. Consequently, individuals' needs are often communicated behaviourally by 'acting out' (Gorman, 2015), which may further serve to reinforce the existing 'us and them' culture.

In sum, existing theory on TC processes has developed from a practitioner perspective, avoided subsection to empirical testing and maintained a generic focus despite the heterogeneous implementation of TCs in complex and specialist forensic settings. Although the single existing high secure LDTC has been evidenced to improve interpersonal difficulties and incidents of physical aggression, current research and theory is unable to imply whether suggested theoretical processes exist within this novel modified treatment setting.

Aims of the current study

The aims of the study were to:

1. Explore both service user and staff members' perceptions of TC principles as outlined by Haigh (2013) and identify whether these are present in the environment of the LDTC within a high secure hospital.
2. Identify whether any further important principles exist within the social climate of the LDTC that are not captured by current TC theory.

Method

[See extended paper]

Design

A single case study design was employed, with the 'case' being defined as the LDTC based at one of three high secure hospitals in the U.K. housing the high secure male learning disability population. A qualitative approach was employed within the case study to enable analysis of TC members' experience and perceptions of therapeutic principles in addition to identification of shared experiences. Data were collected via semi-structured interviews. Questions were adapted for service users to ensure language remained accessible.

The semi-structured interview started with some specific questions about Haigh's five quintessence principles to facilitate a discussion on areas detailed in existing theory.

TC principles are notoriously difficult to capture as they refer to pre-verbal experiences associated with emotionally lived experience (R. Haigh, personal communication, 2015). Interview questions were therefore refined via discussions with clinicians who had previously worked or resided in TCs and were consequently familiar with the philosophy and experiences within such establishments.

Thereafter, a number of broader questions were asked to elicit participants' views on any additional experiences in the LDTC that remain uncounted for by current theory. Questions used enabled service users to use their own language in describing other alternative experiences in the TC. For example, 'If your TC were an animal, what would it look like?' When conducting the interview with service users, a number of additional prompts were used. After initially presenting the first open question, follow up questions (in an either/or format) were used to support the individual in answering the question, if required, without leading them. These questions were implemented to support individuals who find abstract concepts difficult to comprehend and require questions to be more concrete in nature to provide a response (Nind, 2008).

Pictures were used to support understanding and prompts in an either/or format were also provided when required for questions involving abstract concepts.

Ethics

The study was approved by Lincoln University ethics committee and Leicester Central NHS Research Ethics Committee.

Recruitment and data collection

Participants (staff members and service users) were recruited from a male LDTC at one of three high secure hospitals in the U.K. All TC members were invited and therefore no specific sampling strategy was used.

The inclusion criteria for staff member participation were: permanent employment within the LDTC for a minimum of three years to ensure individuals harboured a thorough understanding of the processes of this complex treatment modality.

Similarly, all staff members were required to be able to communicate and understand verbal/written English to facilitate full engagement in the interview process. Those who did not meet the inclusion criteria above were excluded from the research, although everyone who volunteered to participate met inclusion criteria.

Ideally, equal numbers of service users and staff members were aimed to be interviewed within the study. Before commencing the interview, all participants reviewed the information sheet and had the opportunity to ask questions prior to signing a consent form. Interviews were completed by the first author and lasted between 59-103 minutes.

Participants

Twelve participants took part in the study (six staff members and six service users). Out of the 12 service users invited to take part in the study, six (50%) consented to take part. These individuals did not provide any reasons as to why they did not wish to engage with the research and due to lack of consent it was not possible to explore demographic information and determine whether these individuals differed in any way to those who participated.

Twenty out of 40 members of the staff team remained on permanent night shifts and it was therefore not possible to recruit these individuals in to the research. Out of the remaining 20 staff team members, seven (18%) staff members were eligible to partake in the study based on permanently working on the LDTC and having equal to or more than three years of experience in working in the setting. Six of the seven eligible individuals consented to partake in the study (one TC Manager, two Nurses and three Healthcare Assistants). Again, the individual who declined to participate did not provide any reasoning for their decision not to participate.

All service user participants were male. Two staff participants were female and four were male. All service users' IQ scores resided within the mild range for learning disabilities. Table 1 details further participant demographics of those who took part in the study in the LDTC.

Table 1: Participants demographics – means and ranges

	Service users	Staff
Age	38 years (range 27-50 years)	42 years (34-53 years)
Time spent on LDTC	4.5 years (2.5-5 years)	5 years (4-5 years and 11 months)
Time spent in high secure hospital	8 years (2.5-13 years)	N/A

Analysis

The interviews were recorded with a digital Dictaphone and transcribed verbatim. The data was then subjected to deductive content analysis (Mayring, 2000). Inductive thematic analysis was performed on remaining data. This followed a six-step process described by Braun & Clarke (2006). Saliency analysis (an enhancement of thematic analysis) was then utilised to justify the selection of themes and ensure identification of codes that did not recur although remained important to the research questions posed (Buetow, 2010) (see extended analysis).

Trustworthiness

To ensure trustworthiness, the following four criteria were adhered to throughout the study; credibility, transferability, dependability and confirmability (Guba, 1981; Shenton, 2004). To increase credibility and transferability of analysis and results, supervision was used regularly.

In addition, a wide range of informants were utilised in the form of staff and service users to verify individual view points and experiences against others and thus gain a more stable view of reality.

Further, to ensure credibility of the deductive coding template, a colleague and the first author independently coded two transcripts (one staff and one service user transcript) to improve reliability of ratings provided for the qualitative responses.

To establish inter-rater agreement, coded staff and service user transcripts were subject to statistical analysis in order to account for the possibility of chance agreement (Weber, 1990). The averaged Kappa coefficient across all five categories coded for was 0.79 for the service user transcript and 0.80 for the staff transcript, both indicating 'substantial agreement' (Viera & Garrett, 2005). The final set of coded data represents agreed ratings. To address dependability, an audit trail was completed comprising of transcripts and annotations. Confirmability of findings was increased by engaging in a reflective process throughout the research, in the form of a research diary.

Results

[See extended paper]

1. Are Haigh's (2013) quintessential elements of a therapeutic environment present in the environment of the LDTC within a high secure hospital according to service user and staff members' perceptions?

Overall, staff and patient responses were consistent with Haigh's quintessence principles of therapeutic environments. The majority of participants (staff and service users) reported to experience all five of the quintessence principles in the LDTC (please see Table 2 below).

Table 2: Categories endorsed by participants based on Haigh's quintessence principles

TC Principles	Patient responses (frequency mentioned and by how many)	Staff responses (frequency mentioned and by how many staff)
Attachment	(5/6)	(6/6)
Containment	(6/6)	(6/6)
Communication	(6/6)	(6/6)
Involvement and Inclusion	(6/6)	(6/6)
Agency	(6/6)	(6/6)

For example quotes for each of the following categories, please see Appendix S and also extended results section within the extended paper.

Attachment

The first category posed by Haigh (2013) required for 'secondary emotional development' relates to attachment. Both service users and staff described experiences of attachment within the LDTC. Five out of six service users referred to experiences of belonging and feeling valued. Similar experiences were described by all participating staff. Comments pertaining to attachment were made to a lesser extent compared to participants' experience of other TC principles.

Containment

The second category proposed by Haigh (2013) relates to containment (opportunity to express emotions and gain valued support, awareness of boundaries). Service users mainly mentioned valued experiences of support from both peers and staff.

While staff frequently mentioned experience of valued support, they also commonly referred to the importance of giving people time and space to display and experience emotions without immediate staff intervention. All service users (6/6) and staff (6/6) mentioned containment.

Communication

Communication was the third principle put forward by Haigh (2013) in his understanding of what constitutes a therapeutic environment. Service users mentioned experiences of enquiry, commentary, and questioning. References were also made to feeling safe in the fact the community will accept what they have to say. Similarly, staff mentioned the above features of communication. All service users (6/6) and staff (6/6) demonstrated experience of communication.

Involvement and Inclusion

The fourth principle refers to involvement and inclusion. Service users described involvement and inclusion as mainly promoted via peer pressure and rules and procedures. Staff members also regularly mentioned the above features, in addition to staff intervention to promote involvement and inclusion. All participating service users (6/6) and staff (6/6) experienced the concept within the LDTC.

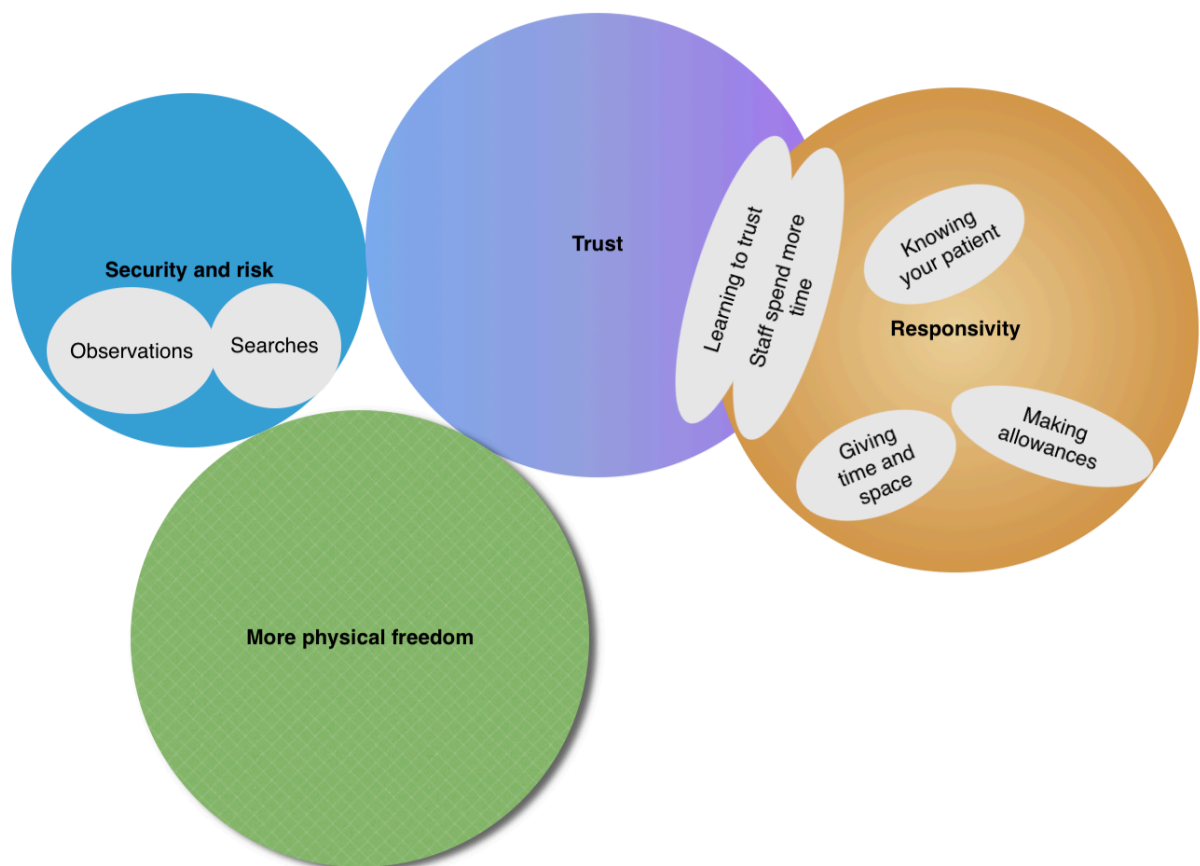
Agency

The final principle posited by Haigh (2013) relates to agency. Service users mainly referred to experiences of agency involving shared responsibility within specified limits. Staff also frequently referred to experiences of shared responsibility, in addition to peers policing each other. All service users (6/6) and staff (6/6) described experiencing the concept of agency within the LDTC.

2. Do any further important principles exist within the social climate of the LDTC that are not captured by current TC theory?

The results are presented with reference to a thematic map (see Figure 1), which outlines a number of themes related to additional principles in the LDTC environment along with their prevalence/importance. The main themes identified were labelled Security and Risk, Trust, More Physical Freedom and Responsivity. The themes and their respective subthemes are discussed below. The paper focuses specifically on those themes that were recurrent and important to participants as to be considered a TC principle, concepts need to be generaliseable to the LDTC as a whole. Other important but not recurrent themes included; 'moving on', 'being reflective', 'staff fit with the LDTC'.

Figure 1: Thematic map



Security & Risk

While not mentioned as frequently by service users (2/6) security and risk was discussed more regularly by staff (5/6). When talking about security and risk, participants highlighted two subthemes, which relate to management of security and risk within the LDTC and its high secure status: 'observations' and 'searches'.

Observations

Two service users highlighted being placed on clinical observations occurred from time to time on the LDTC and that it can be 'hard getting back' to where you were before:

[...] And getting back up is the hardest part of doing it because you know if they like put you on sight and sound or something like that you know you've got to be good to get off that sight and sound or they can put you on watch where you go in your room at night-time they either leave your bedroom door open special watch or your hatch open, you've got to be spot on to have it shut, you've got to be alright that's quite hard getting back up over that.

One patient went on to describe the restrictions experienced when placed on high level observations in more detail impacting on their opportunity to engage in off ward activities:

[...] Yeah or not taking any medication with me if I don't take my medication I'll have my keys took off me, me bedroom locked, day-room bound, can't move, can't do anything, got to hand my keys into them so I mean I'm one of the worst people on the ward to get hit if they refuse anything because I'll get everything stopped and I can't afford that nowadays and I hate staying on the ward.

A further participant went on to explain how lower level observations, such as overseeing interactions between visitors and service users, are more flexible and remain dependent on visitor preference; something that does not occur on other wards:

[...] Like for example with you being in this room now like you said you could have had a member of staff in with us if you wanted, if we wanted one, on other wards it would have been if we'd wanted it or not a member of staff would be sitting in with you, a member of staff would be in the corner near the door and we'd be here doing our talk and the member of staff would be observing at all times but since we're on a therapeutic community the member of staff's only like even not that far away, he's on the bench watching us and he's watching us from a distance but on other wards a member of staff would be in the room while we're doing this one-to-one or this session what you're doing for your research.

Searches

Five staff members discussed the use of patient searches as part of high secure hospital policy:

[...] Umm, I mean obviously working within high secure there are policies there so in a sense, at times, that's where the decisions come from so for example if you're going off ward then you have to have a rub down search, that's in the policy so that's not staff making that decision that's working within the policy.

One member of staff went on to describe the variety of searches service users experience on the LDTC and service users' acceptance of such procedures on the LDTC:

[...] I mean there are, there are certain things that obvious security things that, you know, there's no question about they will have a room search done once a month, they'll have a couple of locker searches done, they will be subject to rubdown searches on their way out, there's the obvious things like that and they all accept that, they know that's out of our hands we have to do that, it's for their safety and our safety, they'll accept that.

Trust

This theme ties in with security and risk, in that flexibility with security conditions remains dependent on trust between staff and service users. The importance of 'trust' within the LDTC was mentioned frequently by both service users (4/6) and staff (5/6). Participants who spoke about trust in the LDTC highlighted two subthemes relating to how trust is developed between service users and staff along with its importance and influence on care provision: 'learning to trust' and 'staff spend more time'.

Learning to trust

Both service users (3/6) and staff (2/6) spoke about trust as a learning process in order to be able to communicate openly with each other. For example, one patient stated:

[...] Why because you've got to learn to trust them to be able to talk to them about problems and childhood and all sorts and all your past history and everything.

This sentiment was further echoed by staff members:

[...] Again I think it builds up their trust that maybe individuals have found very hard to have in the past, maybe a lot of their history hasn't allowed certain individuals to trust people and they find it hard to trust people maybe on here it's just sort of I say twenty-four hours it can happen say that trust just sort of gets another sort of brick added to it on a daily basis then cements that relationship, which then allows more openness, again the relationships build and build and develop, again that's the model patient to patient, patient to staff, staff to patient.

One staff member described trust between staff and service users to develop via patients observing staff members support other service users with their problems:

[...] Things were being brought up and things were getting sorted pretty quickly and they were starting to see that, oh if I've got a problem my problem will be sorted pretty quickly and I think that's what brought the trust together if you like ... and I think that's how the trust just built itself over the years we've been here.

Staff spend more time

An additional method through which trust is built may be through time. Five participants (1/6 service users 4/6 staff) expressed valuing spending time with each other on the LDTC. From one service user's perspective, they felt this showed staff 'care for patients':

[...] But on the TC you've got staff who just spend time being around patients, care for patients instead of being somewhere else, i.e. like office or kitchen.

Similarly, some staff members linked engaging in 'simple' activities on a regular basis with the development of staff and patient relationships:

[...] We spend a lot of time doing things, simple things together, it may only be sitting playing cards, it may be sitting playing Monopoly but we spend a lot of time with our patients and that makes relationships far easier.

[...] there's no like budget to buy staff meals and all that type of thing so staff do sit down like on an individual basis and have their own sort of food with patients.

More Physical freedom

'More physical freedom' shares links with security and risk, and trust, as participants portrayed providing service users with freedom as remaining dependent on trust held between staff and patients and ultimately overall limits set by the hospital in order to manage security and risk. Both service users (5/6) and staff (4/6) frequently spoke of how much they valued the extra physical freedom afforded to patients within the TC.

From a service user perspective, one individual stated:

[...] it's more laid back than the other wards, on the other wards if you've been in the dining room and you get up and go to your room and then you've got to go to bed at a certain time. On here you don't go to your room until quarter to nine and then after you've done your groups, like when you do your group on a Friday afternoon then there's more time to do what you want to do but you can't do that on other wards, you can come in here, go on the Wii, have a cup of tea whenever you want, you can't do that on any other wards.

A number of staff members highlighted how patients do not need to ask permission to move around in their environment:

[...] Basically what I've seen in the past they're told to sit down, they have to ask to get up, to go to the toilet and all that, whereas on here there's a lot more sort of freedom, they can go to their rooms when they want if they've not got activities and things.

One patient went on to describe how the physical freedom afforded to patients enables staff and patients to sit together outside of meetings and 'have a laugh':

[...] But when you're on the ward after the meetings you can still sit and have a laugh and a joke with everybody, it's not like some wards where it's all strict, day-room bound and all doors locked off, all doors are open.

Responsivity

The importance of the final theme, responsivity, was also highlighted to a similar extent by both patients (4/6) and staff (5/6). Three subthemes were identified based on three main ways TC members described tailoring their approach in responding to situations within the LDTC: 'knowing your patient', 'giving people time and space' and 'making allowances'.

Knowing your patient

This theme ties in with the prior theme of trust, particularly in regard to 'staff spending more time' with patients and 'learning to trust'. Four out of six staff members reflected on how time spent informed knowledge gained about patients and helps to build relationships between staff and patients:

[...] I like that all staff have an in depth knowledge of patients, nursing assistants and qualified staff, an in depth knowledge. The relationships on here that have built up because of the knowledge that staff have got and the experiences that the staff have had with the patients.

[...] But obviously the TC, everybody knows everybody, well staff know, staff know the patients, they know their problems and that's the difference in working anywhere else.

A number of staff members expressed how knowledge held by staff regarding patients along with the relationships built have a direct impact on care provided by informing the way staff approach patients. For example, one staff member described noticing a change in a patient's body language, and by having some knowledge of the patient they were able to act on this and offer support:

[...] But you know you can tell by body language basically that a certain individual, you know something's not right...having worked with those patients for so many years, you know when something's not right and you can approach a patient and say look, you know, what's happening.

Giving people time and space

A number of patients (3/6) discussed the importance of providing people with time and space on the TC when tailoring their approach to individuals. From a patient perspective, three individuals expressed how much they valued the time and space given by staff, and particularly peers, to talk when they are ready, which had not been provided to them on other wards:

[...] Yeah but some days you might find it hard, like on this ward you have to talk about what's troubling you straight away and then you can talk or we'll give you a bit of space and time and then you can talk when you're ready, not there and then but on other wards probably get told no you need to talk it now.

[...] It all depends what kind of mood you're in, if you're not in a good mood you want to be alone then, patients respect that and give you a bit of space.

One patient went on to express how fellow patients look out for each other and warn others to give people space when they need it:

[...] that person who's the same group as you asks how you're feeling and you say to that person that you're not feeling alright, then that person gives you a bit of space and if that person sees someone else trying to keep asking then that person who's asking are you feeling alright and that person no you're not, then that person tells the other person just to leave you alone.

While providing people with time and space to choose when to share their difficulties with others, patients continue to monitor other peers' wellbeing when they are aware they are 'not alright':

[...] But even sometimes when you know they're not alright they'll still say yeah which is frustrating when you know you want to help but obviously if they don't want it at the time you've just got to wait and just keep an eye on them to make sure they're alright.

Making allowances

A further way of adapting methods of responding to others was highlighted in the form of 'making allowances'. More staff (3/6) than patients (2/6) discussed the use of making allowances for others depending on the situation. All three staff members discussed remaining 'sensitive' to 'mitigating circumstances'. For example:

[...] Sometimes there can be mitigating circumstances with certain things and then obviously we'll be sensitive to that and probably won't follow certain things through if that's the case.

[...] The only time where we sort of say to them, you know, fair enough, you'd ask them if they're not very well or they've had bad news or whatever, then fair enough but if they're just basically like I'm not going [to the community meeting] then there's consequences for them.

Two patients went on to confirm this based on their own experiences. One patient described the following scenario:

[...] Like tonight we can go mixing on the other side, Thursday you don't mix but if I'd had a bad phone call from my family I just see a member of staff and say can I have permission to go and speak to someone over there so I can get a bit of support because this has happened nine times out of ten they'll say yeah go on, just let the staff know, that's what you get.

Existing TC principles and additional principles – A summary

While the majority of staff and service users confirmed experience of TC principles in the LDTC, a number of additional features in the environment were also identified via inductive analysis.

Security and risk can be considered linked to containment in that conditions of security comprise some of the boundaries via which members are aware of what behaviour is and is not permitted in the LDTC. However, due to the high security status of the hospital, these boundaries are qualitatively different to that which may be found in, for example, a community day TC or even low/medium secure TC and therefore deserve individual consideration.

The theme of trust is clearly linked to concept of containment in terms of TC members experiencing a degree of emotional safety enabling them to communicate their difficulties to TC members to access support. Features that support members developing a sense of emotional safety appear related to development of attachments between staff and patients, facilitated by staff spending more time with service users and patients seeing other members' problems become solved through process of involvement and inclusion. 'More physical freedom' harbours links with communication, in that physical freedom facilitates further opportunities for informal conversations to take place.

Finally, the theme of responsivity is linked to containment, communication, involvement and inclusion and agency, as depending on the situation at hand this may involve applying one or a combination of these principles. However, prior to this, the individual is required to consider the service users' current presentation/circumstances and consider how best to approach and/or support them based on this, which may involve flexibility in application of all TC principles. For example, giving people time to feel comfortable to communicate with others and/or receive support alongside forgoing community meetings where appropriate and necessary.

Discussion

[See extended discussion]

Existing TC principles

Overall, the majority of service users and staff confirmed Haigh's TC Principles as evident in the LDTC environment. One service user did not comment on their experience of attachment within the LDTC. One could hypothesise the absence of comments around developing attachments with peers and staff is indicative of limited experience of the attachment principle within this environment.

Difficulties in developing therapeutic relationships have been reflected in existing literature exploring implementation of the TC model within secure settings (Polden, 2010). Due to the nature of the environment, management of security and risk are often prioritised over development of relationships between staff and service users resulting in fractured relationships (Polden, 2010).

Additional TC principles

Two additional features in the environment were identified in analysis, which were both recurrent and considered important by the majority of staff and service users; More physical freedom, and Responsivity.

While these features may not primarily contribute to the experience of secondary emotional development outlined by Haigh's (2013) five quintessence principles the above themes remain important considerations within therapeutic environments in light of their role in facilitating enactment of TC principles within secure environments, such as the LDTC.

More physical freedom

More physical freedom plays an important role in facilitating existing TC principles. Typically physical freedom is constrained in high secure settings (Polden, 2010).

While Haigh's (2013) principles focus on the emotional culture of an environment, practical elements, such as increased physical freedom, are required in order for service users to have opportunities to engage in therapeutic interactions with peers involving communication, expressing emotions and experience these being contained by peers/staff, in addition to being able to start practicing agency over their own behaviour in simple ways such as choosing where to locate themselves. The importance of physical freedom has previously been highlighted by Moos (2012). Similarly, Moos (2012) suggested physical space within a given setting could facilitate increased social and recreational activities, leading to increased cohesion amongst individuals.

Responsivity

Participants also considered responsivity from staff and peers important within the LDTC. By spending time with service users, staff gain further knowledge about individuals and are able to adapt how they respond in terms of bearing in mind individual circumstances when applying TC principles and considering the nature of support required in the present moment. As a result, service users felt their individual needs were more adequately gauged and responded to by the team.

Individuals' needs within group therapy have commonly been understood in relation to attachment literature (Fried, 1970; Mahler, 1968). Mahler (1968) suggested individuals navigate a 'separation-individuation' deficit involving initial connection with one's surrounding environment before separating from attachment figures to develop a sense of self and identity.

The three stages (hatching, practicing and rapprochement) require careful navigation and each individual will travel along their own trajectory at their own pace. As some service users interviewed had resided at the TC for 4.5-5 years, they may have passed through to the rapprochement stage (Mahler, 1985), where they are focused on developing their own identity/separate from group placing more value on agency. Consequently, these individuals' needs may differ from those who have resided at the TC for a shorter duration.

Flexible application of TC principles may therefore be important in order to remain responsive to TC members and their current needs based on the developmental stage they have reached during their time on the LDTC.

However, responsivity and the subthemes within it were mainly discussed in relation to staff being responsive to patients versus patients being responsive to staff. Consequently, descriptions of how care is provided and who provides care (largely staff for patients) may have implications for how far the agency principle can be enacted in a high secure environment such as the LDTC, with respect to a flattened hierarchy. Recommendations for exploring this issue further are made in the 'research implications' section.

Security and Risk

The theme of security and risk was mainly emphasised by staff and slightly smaller than other three themes. The theme of Security and Risk is largely related to the nature of the LDTC running in a high secure setting (Polden, 2010) rather than being an additional therapeutic principle. However, this remains an important area for consideration in regard to how and whether existing TC principles can be employed around management of security and risk.

Trust

Trust was also considered important by TC members in order to allow people to feel safe that communicating their problems to staff and patients will lead to support and containment. Staff also learn to trust patients, for example, by providing them with more physical freedom. While trust can be understood in relation to Haigh's (2013) conceptualisation of the containment principle and TC members experiencing a sense of emotional safety, it remains a particularly pertinent concept for consideration in secure settings where relationships between staff and service users are often fractured (Polden, 2010).

The importance of trust has been reflected in Erikson's (1998) psychosocial theory of development, specifically the Hope: trust versus mistrust stage (0-1 years). As a result of sufficient attachment experiences (being nurtured and loved), individuals develop a sense of trust in others. Without this, the infant develops a high level of mistrust, causing them to become withdrawn in later life.

Sufficient exposure to the attachment principle in TC environments (engendering a sense of belonging and feeling valued) and involvement and inclusion (seeing others needs consistently met by staff as caregivers) may create a sense of trust in others, encouraging communication and providing opportunities for containment.

Clinical implications:

Does the LDTC fit with a high secure system?

While Haigh's (2013) TC principles are evident in the novel environment of the male LDTC, it is evident that the high secure nature of the LDTC environment modifies and influences their implementation, particularly in regard to agency, and possibly attachment. This is not necessarily surprising, as mentioned above, existing literature has highlighted difficulties in maintaining therapeutic relationships (Polden, 2010) and program integrity in TCs based in secure host institutions, with particular reference to limits imposed on agency (Rawlings, 1998).

While there are specified limits to the amount of agency service users can experience, there is still evidence of its existence, particularly with regard to service users being empowered to have a say in how their community is run (see Appendix S).

Implementation of TC principles within a high secure setting appears aided by additional principles of responsivity and more physical freedom. While trust is captured within Haigh's (2013) principle of containment, it is particularly important emphasis is placed on developing a sense of trust between staff and service users via purposeful effort of the community engendering an experience of emotional safety for TC members.

Relationships in forensic settings between staff and service user groups are often characterised by hostility and mistrust (Polden, 2010). In addition, individuals with an LD can lack the capacity to manage or think about their feelings and therefore communicate their needs behaviourally by 'acting out' in an attempt to rid themselves of their feelings (Gorman, 2015). However, with increased physical freedom, TC principles of involvement and inclusion and open communication can be fully enacted. Strong therapeutic relationships can be developed that are able to tolerate high levels of aggression and risk within LD/PD forensic populations (Alexander et al., 2006; Torr, 2008).

These relationships provide a platform for trust to grow, enabling staff to respond flexibly and effectively to each individual's needs.

The future of the LDTC

Compassionate and nurturing relationships are of particular importance to forensic LD populations in light of frequent experiences of historically being deprived of having the opportunity to be responsible over their own care (Taylor, 2010). Such issues lie at the centre of Transforming Care Paper (NHS England, 2015).

The principles inherent in the LDTC environment could provide a pathway for forensic populations with a dual diagnosis of PD and LD in conditions of high, medium, low security and step down facilities. This pathway could help to both safeguard individuals from abuse via communication and involvement and inclusion, and emphasise individual agency, while supporting service users to apply skills from the TC to external/'real life' environments, as risk reduces.

Limitations and research implications:

A strength of the study is that it provided an in-depth exploration of TC principles within the only existing male LDTC in a high secure hospital, and recommendations for the direction of future research in this area.

The study was performed within a single case study design and therefore results remain specific to this LDTC. However, the finding of TC principles in such a unique setting may indicate Haigh's (2013) TC principles are evident in other, less constrained, TC environments. As there is no existing research exploring TC principles in LDTCs in lower conditions of security or non-secure settings, this highlights an area for future research to explore.

The study should also be interpreted with reference to its limitations. Participants who left the LDTC prior to treatment completion could not be invited to take part in the study due to no longer residing at the hospital. This may have excluded alternative perspectives on TC principles inherent within the LDTC.

The study also neglected to explore reciprocity of TC principles more explicitly with staff members. For example, within the interview schedule the research could have enquired further in regard to staff experiences of communication in terms of how open they are with service users and information they choose to disclose or not disclose. Consequently, the research provides limited information on whether and how TC principles work on a two-way basis between service users and staff members. To explore this further future research could take the form of naturalistic observations via an ethnographic study.

Being able to observe processes within the LDTC as they unfold may help to investigate how far TC principles, such as agency, and other features of general care such as 'responsivity' are enacted within a high secure environment and determine how much these features apply to staff as well as service users.

While the study identified existing and additional TC principles inherent in the LDTC, it did not specifically consider how these might inform outcomes within the LDTC. One method of linking principles and outcomes may be to evaluate how important TC principles are to individuals. The importance of TC principles to staff and service users may have implications for the development and maintenance of individual and group alliances between staff and service users. This could also provide a focus for future research in order to clinically inform future LDTC environments in high secure settings.

Future research could develop a process-based measure made up of statements representing core processes in the LDTC agreed to exist by the community. Statements could be derived from qualitative data from this study detailing therapeutic principles inherent in the LDTC environment. Participants could then be asked to individually sort the statements in terms of importance, for example utilising a Q sort procedure. Each individual's Q sort could then be subject to quantitative analysis to identify mutually agreed important therapeutic elements of the social environment as identified by the community.

Conclusions:

While the high secure nature of the LDTC appears to modify and influence application of TC principles to the environment, findings of the study highlighted confirmation of existing TC principles in this niche and novel environment by staff and service users. Staff and service users also confirmed a number of additional features within the LDTC environment.

While these features are not primarily linked to Haigh's (2013) principles they help to facilitate implementation of existing TC principles that provide an experience of secondary emotional development within a therapeutic environment in conditions of high security; Responsivity, More physical freedom. While the theme of trust is captured within Haigh's (2013) conceptualisation of the principle of containment, it is argued this principle requires particular attention within secure settings in order to develop a sense of emotional safety within an LDTC. It seems prudent these additional elements are emphasised and nurtured in order for the LDTC to continue to thrive in a high secure setting, and potentially conditions of lower security in the future.

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Extended Paper

1. Extended Background

1.1 Overview

This section expands on the introduction presented in the journal article by introducing DTCs in addition to other existing treatments available for a forensic LD clinical population. While there is a growing literature on the effective use of Democratic Therapeutic Communities (DTCs) in the treatment of personality disorder in LD populations within forensic settings research has been limited by problems encountered in measuring such a complex treatment modality. Existing theoretical frameworks have been developed in an attempt to understand core principles of how TC and other group therapy environments provide effective social climates for therapeutic change. However, existing theory has been developed from a practitioner standpoint and remains generic in nature. Consequently, principles have yet to have been explored in relation to novel settings such as the single high secure learning disability therapeutic community (LDTC) at a high secure hospital which is the purpose of this research.

The following section details the background on Democratic Therapeutic Community (DTC) history, types of TC, efficacy in treating LD populations and problems with measuring TC treatment efficacy. It reviews theoretical frameworks exploring features of therapeutic environments, and common factors relevant to outcomes in psychotherapy, retaining a broad focus within the discussion of existing theoretical frameworks, as while therapeutic environments and other psychotherapies differ in certain therapeutic components, a number of areas of overlap exist between these treatment modalities and DTCs. However, the core focus of the literature review resides on theories developed containing key processes or principles considered of importance to social climate supportive of therapeutic change.

Finally, implications of a shared understanding of important TC principles are considered in relation to individual and group therapeutic alliance before discussion of the rationale for the current study, aims and objectives.

1.2 A summary of available treatments for LD/PD forensic

Literature on treatment of male offenders with both an LD and PD remains limited, largely as a result of 'diagnostic overshadowing' – difficulty differentiating between symptoms of LD and PD, leading to under diagnosis (Taylor & Morrissey, 2012) and in some cases exclusion from treatment (Loucks, 2007). A discussion of available treatments and evidence is considered below:

1.2.1 Cognitive Behavioural Therapies

Research on treatment for offenders with LD in general has indicated beneficial outcomes from Cognitive Behavioural Therapy (CBT) to meet needs such as regulation of aggression and anger (Lindsay & Smith, 1998; Lindsay, Marshall, Nielson, Quinn & Smith, 1998a; Lindsay, Nielson, Morrison & Smith, 1998b; Lindsay, Olly, Jack, Morrison & Smith, 1998c; Lindsay, 1999; Taylor, Novaco, Gillmer & Thorner, 2002), sex offending (Heaton & Murphy, 2013; Williams, Wakeling & Webster, 2007), and fire setting (Clare, Murphy, Cox & Chaplin, 1992) and have consequently been implemented in treatment pathways for this population. Treatment largely comprises of targeting and modifying maladaptive cognitions and patterns of thinking that prevent or undermine more adaptive behavioural responses (Matusiewicz, Hopwood, Banducci & Lejuez, 2010).

Some evidence has also become available for third wave cognitive behavioural therapies such as Dialectical Behaviour Therapy (DBT), involving a combination of cognitive and behavioural approaches with elements of Eastern philosophy (mindfulness and meditation) (Sakdalan, Shaw & Collier, 2010; Sakdalan & Collier, 2012).

DBT focuses on provision of skills in four core areas; mindfulness skills, toleration of distressful feelings, identifying and regulating emotions and interpersonal problem solving and assertiveness skills to increase propensity for managing emotions and decrease risk behaviour (Morrissey & Ingamells, 2011).

Although, outcome studies remain limited in this area specifically for offenders with LDs and a diagnosis of PD, emerging evidence has been produced for this model via implementation of a modified version of a DBT program, piloted at the National High Secure Learning Disability Service (NHSLDS) from 2004 onwards for men with mild LDs (Morrissey & Ingamells, 2011). Modifications included additional group sessions, simplification of complex DBT concepts, handouts containing pictures and symbols, and smaller groups (maximum of 5 people). From 2004-5, six individuals who completed the 18-month program showed promising results (Ingamells & Lascelles, 2004). Significant reductions were shown in self-report measures such as the global severity of distress scale located in the Brief Symptoms Inventory (BSI; Derogatis & Melisaratos, 1983). Risk was also reduced, with the treatment group being more likely than a waiting list control group (n=5) to move on to conditions of low security post 12 months treatment. However, as participants received a number of additional interventions during attendance at the DBT program (pharmacology, offence focused programs), differentiation of DBT treatment effects from other interventions has not been possible.

1.2.2 Psychodynamic therapies

While no evidence is currently available for offender populations with both an LD and PD, some outcome studies exist in regard to one to one and group psychodynamic therapy for male LD offender populations in general (Taylor & Morrissey, 2012). Beail (1998) evaluated outcomes in men with LDs who received once weekly one to one psychodynamic therapy, eight of which had committed offences previously.

Interventions were based on free association and therapist interpretations with a median treatment duration of six months. All eight individuals committed no further offences during treatment and this was maintained at six-month follow up. In a further study, Beail (2001) assessed outcomes of 13 men with LDs referred for psychodynamic therapy from the Criminal Justice System. Follow up at four years identified two out of 13 men had re-offended.

However, underlying processes for successful treatment have not been identified and it is therefore difficult to differentiate specific treatment effects from the humanistic element of social contact (Bhaumik, Gangadharan, Hiremath, Swamidhas & Russell, 2011). Macdonald, Sinason & Hollins (2003) explored nine individuals' general experiences and satisfaction with two psychodynamic therapy groups. Four of the group attendees had previously attended a sex offender group. Qualitative analysis from interview data indicated while participants felt valued and included by the group, at times the group was experienced as painful and individuals were often unaware of positive change in themselves. Due to limited evidence base for psychodynamic therapy, such interventions are uncommon in forensic settings and more generally for individuals with an LD (Bhaumik et al. 2011).

1.2.3 Mentalisation Based Therapy

More recently, Mentalisation Based Therapy (MBT), an attachment and psychodynamically oriented psychotherapy, has been used with individuals who have diagnoses of personality disorder. Mentalisation based therapy is a time-limited treatment which utilises interventions to promote mentalising. Mentalisation involves the ability to read and be aware of our own intentions as well as other people's and to be able to regulate thinking and feeling simultaneously (Adshead, 2015; Bateman & Fonagy, 2010: 11; Fonagy, 1989).

Unfortunately, those with insecure attachments tend to have a low mentalising ability due to previous caregivers remaining unable to understand and respond to their internal states during infancy. In adulthood, individuals go on to struggle with their experience of distress and ways of responding to this, negatively impacting on relationships with others (Adshead, 2015). While limited evidence is available for offender populations with a diagnosis of PD, some outcome studies exist in regard to one to one and group MBT for PD treatment in general (Bateman & Fonagy, 2013; Bateman, O'Connell, Lorenzini, Gardner & Fonagy, 2016).

Recently, a pilot randomised controlled trial was completed comparing 18-month weekly combined individual and group MBT treatment with structured clinical management (problem solving and social skills) at 6, 12 and 18 months for individuals with diagnoses of comorbid Borderline and Antisocial personality disorders. Outcomes demonstrated MBT was more effective in terms of reduction of anger, hostility, paranoia, frequency of self-harm and suicide attempts, improvement of negative mood, interpersonal problems and social adjustment (Bateman et al., 2016). Recently, use of MBT has been explored within a high secure setting with individuals with a PD diagnosis (Ware, Wilson, Tapp & Moore, 2016). An interpretive phenomenological analysis suggested enhanced mentalising capacity post treatment, positively impacting on individuals' ability to manage their behaviour and emotions (Ware et al., 2016). However, no research currently exists in regard to implementation of this treatment approach with individuals with a forensic history and dual diagnoses of learning disability and personality disorder.

1.2.3 Therapeutic communities and social milieu approaches

Therapeutic communities (TCs) have a longstanding recognition for providing a safe and humane environment within forensic service provisions for offenders (Cullen & Miller, 2010; Genders & Player, 2004; Newton, 2010).

Indeed, the social climate of a treatment setting has been shown to have important implications for increasing responsivity to treatment amongst service users (Moos, 1973; Ward, Day, Howells & Birgden, 2004) and also have psychological benefits for staff (Little, 2014; Mistral, Halls & McKee, 2002; Houzel, 1996; Shefer, 2010), such as an increased resilience facilitating a strengthened ability to contain, rather than retreat from, the emotions of others (Hinshelwood, 1999; Moore, 2012). Forensic settings often harbour a hostile and mistrusting culture, prioritising management of security over therapeutic relationships (Clarke, 1996; McManus, 2010; Shine, 2011).

Additionally, it is well established that staff attitudes towards individuals with a diagnosis of personality disorder are generally negative and pessimistic in regard to treatment efficacy and outcome (Bowers, McFarlane, Kiyimba, Clark & Alexander, 2000; Newton-Howes, Weaver & Tyrer, 2008), particularly in secure settings (Bowers et al., 2006). As a result, open and honest communication is restricted. For example, staff are discouraged from demonstrating differences of opinion for fear 'cracks' in the team will be exploited by service users with such diagnoses (Neilson, 1991). Boundaries set can become rigid and in some ways punitive (Bowers et al., 2000). Conversely, Critchfield & Benjamin (2006) emphasise the importance of flexible boundaries in supporting individuals with personality disorder diagnoses – flexibly responding to genuine needs of the person while maintaining firm boundaries in critical areas. They go on to suggest potential boundary transgressions require individual consideration, taking in to account knowledge of the service user, to enable staff to respond in a humane and therapeutic way.

It is therefore important service providers address the milieu within treatment settings for PD. The Democratic Therapeutic Community (DTC) model specifically focuses on the social milieu and uses the community as a vehicle for intervention to challenge anti-authoritarian and anti-social attitudes residing in forensic settings.

Consequently, the model may provide a method by which to address relationships within treatment contexts (Taylor & Trout, 2013). Treatment outcomes for offenders with a PD have been enhanced when exposed to treatment that is integrative and eclectic in nature (Bartak et al., 2007; Livesley, 2003).

Livesley (2001) has posited offenders with PDs have three primary areas of need: to develop stable and integrated representations of self and others, to be able to function adaptively as an attachment figure and gain capacity for reciprocal relationships developed adaptively in a social group (Taylor & Trout, 2013). Consequently effective treatment of PD is considered to require attention to a range of domains within the personality system (Livesley, 2001; Livesley, 2003; Livesley, 2007). Therefore it follows multi-modal treatment is required, drawing on a range of therapeutic techniques in a logically coordinated in manner. For example, therapies involving development of emotional regulation and containment via development of a therapeutic alliance will take primary focus initially whereas insight-orientated therapies such as schema therapy may follow later after containment is met.

A DTC is most usefully defined as a treatment modality (i.e. integrating a range of psychological and/or pharmacological approaches) as opposed to a specific treatment method itself (Kennard, 1998). Therefore, comparative to other available therapies, DTCs provide an integrated multi-modal 24-hour therapy, where everyday experiences constitute therapeutic material to be worked through by the community.

Such an environment provides an appropriate context in which to address the complex nature of interpersonal difficulties often apparent within offender populations while forging the development of therapeutic alliances (Shuker, 2010). As noted by Morris (2004, p.36) in describing severe PD pathology, 'with deeply ingrained maladaptive patterns that comprise this group's personality disorder, high intensity, high dose treatment is required'.

An environment of open communication, clear and consistent management of boundaries, use of community agenda to explore and challenge behaviour and allocation of community jobs to rehearse and test new skills allows for an integrated and holistic approach to the treatment of such complex interpersonal pathology (Shuker, 2010).

The open and trusting culture characteristic of a TC could be of particular value to forensic populations LD populations due to the severity of individuals' interpersonal difficulties and double stigmatisation experienced as both an offender and as a person with a disability within prisons and other forensic systems (Morrissey & Taylor, 2014). In addition, facilitation of numerous opportunities for individuals to generalise and apply skills acquired to daily activities outside of formal therapy sessions helps to provide a more concrete learning experience than that offered in 1:1 therapy (Willner, 2006). Indeed, growing evidence has been provided on the efficacy of DTC treatment in forensic LD populations in the form of reduced violence, personality pathology and interpersonal difficulties (Miles, 1969; Taylor, Crowther & Bryant, 2015). Detailed consideration of DTC outcome studies for LD populations is considered below.

1.3. Democratic Therapeutic Communities

1.3.1 *An introduction and brief history*

The philosophical origins of TCs are varied and can be traced within various religious and political movements (Campling, 2001). However, most notably, TCs obtained a number of key ideas from the 'moral treatment' era of the 18th Century (Haigh & Lees, 2008). These include concepts embraced by and implemented by William Tuke in his founding of The Retreat Hospital in 1796 and include the importance of work, a healthy environment and caring relationships with others (Campling, 2001).

These ideas were formulated in an uprising against the predominant approach to mental illness comprising of institutionalisation and marginalisation and provided an important foundation upon which TCs today were built on – the importance of being human with others (Haigh, 2005).

It was Tom Main, a psychoanalytic psychiatrist, who initially coined the term ‘therapeutic community’ (Whiteley, 2004). The concept was used to describe the approach of psychiatric hospitals that emerged during the Second World War, as part of the uprising against marginalisation of the mentally ill, to provide a humane form of treatment for soldiers presenting with symptoms of what might now be understood as posttraumatic stress disorder (Stevens, 2010). Three therapeutic experiments were pivotal in this treatment modality’s development: the two Northfield experiments conducted in Birmingham at Northfield’s Military Hospital (Bion & Rickman, 1943; Bion 1961) and an experiment orchestrated by Maxwell Jones at Mill Hill Hospital in London (Jones, 1946; Jones, 1968; Jones, 1979).

Within both Northfield experiments (Bion & Rickman, 1943; Bion, 1961; Harrison & Clarke, 1992), a group of psychoanalytically orientated psychiatrists of the time sought to challenge the current hegemonic ‘medical model’ of treatment, which was deemed no longer an appropriate means of treatment for a client population exposed to trauma. The model’s predominant values of authoritarianism coupled with the paternalistic delivery of care and hierarchical position of professionals were thought to maintain patients’ position within a sick role, perpetuating their lack of autonomy and exacerbating existing trauma symptoms (Stevens, 2010). A more permissive and empowering milieu was proposed to hold the potential to relieve patients’ symptoms of distress via promotion of a democratic organisational structure and group-based discussions. Wards were structured as communities and mutual peer support was encouraged in addition to cooperating as a community to complete activities of daily living (Main, 1946). Groups were regularly held to discuss and work through social processes within the community and it was within these group spaces the ‘living-learning’ element of a therapeutic community took place (Campling, 2001).

While the Northfield experiments were underway, Maxwell Jones, a Respiratory Physiologist by trade, had developed a growing awareness of the importance of environmental and social processes in inducing therapeutic change (Vandevelde, Broekaert, Yates & Kooyman, 2004). During his work on a psychosomatic unit at Mill Hill Hospital in 1941, Jones worked with soldiers diagnosed with 'effort syndrome' (detected via breathlessness, chest pain, hyperactivity and fatigue) and became aware of the beneficial effects on patients' self esteem and learning when an interactive group discussion was held as opposed to the didactic teaching style that had characterised his previous lectures on the physiological basis of their symptoms (Stevens, 2010).

It was the flattened hierarchy between professionals and patients within group discussions and mutual peer support that appeared to operate as a key catalyst for change (Jones & Lewis, 1941). Jones utilised this discovery to set up a Social Rehabilitation Unit, later renamed as the Henderson Hospital in 1958, to tackle the problems of 'unemployed drifters' in Surrey (Campling, 2001). The Henderson Hospital has since operated as the flagship for the British Democratic Therapeutic Community model since the 1980's (Haigh, 2008).

Maxwell Jones has been nominated as the 'father' for the therapeutic community movement largely due to his multiple publications (Jones, 1946; Jones, 1952; Jones, 1956; Jones, 1959; Jones, 1968) and popularisation of social psychiatry. As noted by Whiteley (2004), while Main is credited with coining the concept of the TC, Jones may be best thought of responsible for devising the therapeutic community method.

1.3.2 Degrees of TC

TCs have been used in various ways across a multitude of settings. Consequently, TCs have been usefully conceptualised by David Clark (1964) in terms of two further categories: the TC approach, and the TC 'proper'.

The former concept can be thought of as more akin to Main's approach to the implementation of TC principles, wherein the entire hospital establishment adopts a TC approach. A TC 'proper', can be thought of as a distinct treatment entity and operates a clear membership boundary, similar to the model of that proposed by Maxwell Jones. Establishments operating according to a TC approach are commonly known as 'therapeutic environments' or 'positive environments' and are most often named Psychologically Informed Environments (PIEs) or Psychologically Informed Planned Environments (PIPEs) within forensic settings such as prisons (Johnson & Haigh, 2011; Turley, Payne & Webster, 2013).

PIPEs are generally associated with prison programmes and utilised within the British Criminal Justice Sector within probation and prison settings (Haigh, 2015). Staff are provided with specialist training to develop increased psychological understanding of their work and there is a particular focus on relating and the quality of relationships (Turley, Payne & Webster, 2013). Like DTCs, PIPEs are used with offenders with complex needs, such as PD, to approach events of daily life in a psychologically informed way and provide a safe and containing environment to help maintain therapeutic gains from high intensity offending programmes, such as DTCs (National Offender Management Service [NOMS] & Department of Health [DH], 2012). A separate accreditation process has been set up, known as 'enabling environments' (EE) through which PIPEs are working towards (or have already fulfilled) standards developed by the Royal College of Psychiatrists' (RCOP) College Centre for Quality Improvement (CCQI) to be recognised as an EE (Haigh, 2015).

PIEs are often utilised within the housing and homeless sector and often implemented when a setting is such that it would prove difficult to run a 'proper TC' (Haigh, 2015). PIEs have been promoted by a separate organisation – the Department for Communities and Local Government in a more fluid and flexible way than prison PIPE programmes (Haigh, 2015).

Like PIPEs, PIEs focus on relationships, a safe and containing environment and psychologically informed staff team with some knowledge of a therapeutic framework (Ritchie, 2015). There is a range within which the above elements have been employed in these environments and as such PIEs have not always joined the EE accreditation process (Haigh, 2015). Instead, they are often understood as part of an 'extended family' of 'positive environments', incorporating values from the therapeutic community approach (Haigh, 2015, p.10).

A TC 'proper' purposely harnesses the reflective potential of staff and fellow peers to support residents of the community to become curious about their own behaviour and develop new ways of being with others. A key feature that sets these environments aside from PIEs/PIPEs is the deliberate flattening of hierarchy facilitating democratic decision making between staff and service users. Flattening of hierarchy can prove difficult in forensic TCs where the nature of service users' difficulties and subsequent risks they pose require increased conditions of security and monitoring. Given this, democracy is preserved and authority is 'loaned' to service users under specific circumstances and conditions (Norton & Bloom, 2004; 251) e.g. letting the community decide about where service users' should be granted leave, consideration of referrals to the TC etc.

Relationships, daily structure and activities are all designed to help individuals' health and wellbeing (Taylor, Crowther & Bryant, 2015). Each working day is usually divided between formal psychotherapeutic activity (small group therapy and community meetings) and educational/occupational activity. Leisure and meal times are also engineered to provide positive prosocial experiences. All members are involved in the planning of weekly activities to promote involvement and group cohesion.

The opportunity and freedom for staff and peers to provide commentary on the behaviour of all community members fosters the culture of openness, empathy and connectedness, while reducing the eventuality of splitting between patient and staff groups (Taylor, Crowther & Bryant, 2015). This form of TC is commonly known as a DTC.

The DTC model has commonly been implemented within the NHS to treat BPD (Borderline Personality Disorder) and other enduring mental health difficulties in the community and inpatient settings in addition to prison settings with the aim of reducing offending behaviour (Community of Communities [C of C], 2015). The DTC model has recently been implemented in one of three high secure psychiatric hospitals in the U.K. Consequently, a primary focus will be placed on DTCs within this literature review.

As Warren et al. (2003) note, it is important to have in mind a number of ideas at this stage. Firstly, what constitutes a TC is not always conceptually clear, and in fact, the TC treatment modality may be more usefully thought of in 'degrees' of the method (for example, 'milieu', 'TC approach'). Secondly, there are several types of TC. Thirdly and finally, what is described as a TC may not be agreed upon by others (and sometimes vice-versa).

1.4 Democratic therapeutic communities today

While working in different institutions, both Main and Maxwell utilised TCs as a treatment tool for individuals with interpersonal difficulties, often hailing from traumatic backgrounds (Whiteley, 2004). Today, TCs continue to be used in varieties of settings (NHS, voluntary and private) within the U.K. and beyond for similar client populations who usually, but not always, have a diagnosis of personality disorder or severe enduring mental illness (Haigh, 2014). Alongside standard inpatient community TCs, day (3-5 days a week with no over night facilities) and mini (one to two days a week) TCs also exist (Pearce & Haigh, 2008).

In terms of clinical populations, TCs have been implemented with children and adolescents, individuals with chronic and acute psychoses, offenders in forensic contexts and also within an LD population (Kennard, 2004). The use of DTCs in the latter two areas will comprise the focus in the following discussion due to their direct relevance to the research. The interested reader may wish to refer to Kennard (2004) for further information on the use of TCs with other client populations.

1.4.1 TCs in secure settings

Two models of TC have been commonly implemented with offenders for the purposes of improving psychological health and reducing risk of recidivism (Lees, Manning & Rawlings, 1999). Hierarchical (concept house) therapeutic communities and the aforementioned DTC model. Concept TCs have their origins in America, and were developed to provide rehabilitation for individuals with substance misuse problems.

The model has been widely used within prison systems in America, while the predominant approach of the U.K. has favoured the use of the DTC model in the treatment of offenders. Concept house communities are often differentiated from DTCs via their implementation of a social hierarchy between patients, and more experienced peers/staff members, with the latter two groups retaining increased authority (Vandeveldt et al., 2004). Another difference often highlighted pertains to the treatment target group of each model. While DTCs focus on individuals with mental health problems and personality disorders, concept house TCs treat individuals for substance misuse difficulties (Haigh & Lees, 2008).

However, overlap between the two models has been noted over recent years. For example, both models describe utilisation of the community as method, and the majority of clients who access either DTCs or concept TCs harbour both mental health problems and substance misuse issues (De Leon, Sacks, Staines & McKendrick 2000; Haigh & Lees, 2008).

Nonetheless, DTCs remain the primary model utilised in the U.K. and wider Europe and continue to be implemented within prisons and secure hospitals as accredited offender behaviour programmes (Cullen & MacKenzie, 2011). For this reason, specific focus will be placed on DTC research within these geographical areas. At the current time, DTCs are in operation in prisons (HMP Blundeston, HMP Dovegate, HMP Gartree, HMP Grendon, HMP Send, HMPYOI Warren Hill) and secure hospitals (e.g. St Andrews Hospital). Most secure TCs admit male offenders only. The demographic group generally comprises of people with personality disorder, although requirements for meeting this diagnosis are not always specified or required (for example, HMP Dovegate – Miller & Brown, 2010). Offenders are admitted into DTCs with the aim of reducing in house violence, promoting open communication and exploration of personal issues (Kennard, 2004). Grendon prison in Buckinghamshire is currently the only institution to operate as an entirely therapeutic prison. All other establishments comprise of smaller units inside larger mainstream prisons (e.g. Gartree, Dovegate), and secure psychiatric hospitals.

1.4.2 TCs for individuals with a learning disability

The use of TCs within a learning disability population stems back to the 1940's where 'intentional communities' were first initiated (Kennard, 2004; Taylor, Crowther & Bryant, 2015). These communities were developed specifically for an LD population, and most commonly known as the 'Camphill Communities'. Based within the community, the aim of the communities was to provide of sense of belonging for individuals often marginalised by wider society. This was accomplished via incorporation of values from traditions such as the 'Christian Mission' and 'Philanthropy' to provide a lifelong residential environment for individuals with LD, as opposed to operating as hospital or community based treatment programs (Haigh & Lees, 2008). A number of core TC elements were adopted within community practice, including emphasis on equal status and the healing value of relationships.

However, use of the psychodynamic model and analysis of social interaction was limited. Instead a particular focus was placed on practical work, as opposed to verbal exchange (Kennard, 2004).

Democratic TC's, which have emerged from Maxwell Jones treatment method at the Henderson Hospital have formed the basis for the treatment-orientated TCs within psychiatric services for people with LD. The use of DTCs for individuals with mental health difficulties and learning disability was initially documented by Miles (1969) who described implementation of a DTC within a secure setting. Miles (1969) utilised the TC framework as a method through which to treat what is now known as antisocial personality disorder. The use of TC principles has been documented elsewhere in the treatment of sex offenders with LDs (Haaven, Little & Petre-Miller, 1990).

The residential treatment program was described to place emphasis on sharing and cooperation of the community in completing activities of daily living, open communication between members, and emphasis on learning via experience with a particular focus on process over performance in activities. Aside from earlier research, literature in this area has been limited until recently (Taylor, Crowther & Bryant, 2015).

Indeed, some authors have suggested individuals with reduced intellectual ability (IA) may be unable to benefit from traditional TC treatment (Newberry & Shuker, 2011). Following a period of TC treatment at HMP Grendon, Newberry & Shuker (2011) identified individuals who were less likely to complete the intervention were those with lower IA. Upon further investigation of psychometric scores, Newberry & Shuker (2011) posited engagement in this treatment modality was problematic for offenders with a lower level of intellectual ability due to increased levels of hostility, psychoticism, neuroticism, criminal thinking styles and blame attribution compared to those with higher IA (effect sizes $r = .01 - .05$).

Newberry & Shuker (2011) suggested these findings represented a higher level of treatment need within this population, which should be acknowledged and addressed in future TC interventions to promote therapeutic engagement and therapeutic change. However, the clinical implications of these findings were limited by the small effect sizes identified and absence of formal assessment of learning disability.

More recently, a number of advances have been made in the use of TCs for individuals with LDs within secure settings, with limited modifications (Taylor, Crowther & Bryant, 2015). Currently, there are three LDTCs in place within prisons (HMP Grendon, HMP Dovegate, HMP Gartree) and also secure psychiatric hospitals (Calderstones Hospital and St Andrews Hospital). All of these facilities cater for males with dual diagnosis of LD and PD. The LDTC exists within one of three high secure psychiatric hospitals in the U.K. and currently remains the only service provision of this kind within a high secure setting. Similar to TC implementation within a mainstream offender population, existing LDTCs are based on the TC 'proper' model associated with Maxwell Jones (Taylor, Crowther & Bryant, 2015).

Recently, a number of these programs have been validated as a treatment by the prison service for offender rehabilitation (HMP Dovegate TC Venture (TC+; a TC adapted for individuals with an LD), HMP Gartree (TC+), HMP Grendon (TC+) – NHS England & NOMs, 2015). A discussion on the efficacy of DTCs in LD populations within the U.K. follows below.

1.5 Efficacy and effectiveness

At present, methodological limitations have clouded conclusions on the utility of forensic TCs in addressing reoffending risk, personality pathology and more generally psychological wellbeing (discussed further below). However, an evidence base is emerging which may allow more grounded conclusions to be drawn around forensic TC efficacy. An international systematic review was conducted on the treatment efficacy of DTCs for people with PD and 'mentally disordered offenders' in secure and non-secure settings.

A meta-analysis of 22 controlled studies (19 of which were DTCs) from 1960-1998 identified a strong positive effect for individuals attending DTCs, with improved relational difficulties and reduced reconviction rates (Lees, Manning & Rawlings, 1999).

Specifically, when compared with treatment delivered in general inpatient wards, forensic TCs have shown improvements post-treatment for admitted patients in the form of reduced rates of reconviction and improvements in interpersonal relating (Birtchnell, Shuker, Newberry & Duggan, 2009; Lees, Manning & Rawlings, 2004; Newton, 2010; Rawlings, 1998; Shuker & Newton, 2008; Thornton, Mann, Bowers, Sherif & White, 1996; Wilson, Freestone, Taylor, Blazey, & Hardman, 2014).

In a review of treatments for severe PD from 1993 – 2001, Warren et al. (2003, p.6) concluded TCs offer the most promising treatment for PD and that ‘the therapeutic community ethos could be used as a dominant approach and structure...of new regimes...and could include other treatments targeting specific aspects of psychopathology’. Within the review recommendations the use of TCs within high secure settings was specifically advocated, with treatments for PD employed within the overall framework.

1.5.1 TCs in secure settings for LD populations

As mentioned previously, there has recently been a resurgence in the use of DTCs within an LD forensic population (Taylor, Crowther & Bryant, 2015). Consequently, a growing number of studies have been completed to assess their efficacy with promising results (Crowther & Clayton, 2013; Crowther, Withers, Chatburn, Capewell & Sharples, 2013; Morrissey & Taylor, 2014). Similar to research in mainstream forensic settings, available studies have been conducted within practice-based designs.

Beginning in the late 1960's, Miles' (1969, p.1052) study was one of the first documented attempts at incorporating the TC method within the treatment of a male LD forensic population with 'behaviour disorders'. At 12 months, a TC and TAU (treatment as usual – inpatient psychiatric ward) groups were compared in regard to attitudes toward authority (measured by self-report questionnaires) and behavioural observations made by staff.

While matching of the two groups was not possible, patients were alternately admitted between both groups providing a more equal distribution of demographic characteristics. At 12-month follow up TC patients exhibited improved attitudes toward authority in comparison to the TAU group. Interpersonal hostility was also notably reduced, with 'misbehaviour' (violence, arguing and bullying) reducing from five to two incidents within the final month (Miles, 1969, p.1055). Importantly, changes were unrelated to IQ scores or severity of attitudes toward authority pre-admission.

More recently, outcome evidence has been provided by a service evaluation conducted on the LDTC within the National High Secure Learning Disability Service (Taylor & Morrissey, 2012). Drawing on the multimodal treatment model for PD advocated by Livesley (2007), the DTC forms the backdrop for other therapeutic interventions (small group therapy – schema focussed approach [Young, Klosko & Weischaar, 2003]) appropriate to the treatment needs of the client population.

As part of the evaluation, seclusion use was compared between both the TC group and a TAU group (receiving offender behaviour programmes and DBT) at 12-month periods (Morrissey, Taylor & Bennett, 2012). Experienced forensic nurses with learning disabilities were recruited in to the staff team. Those without learning disability experience were seconded to forensic LD settings within the hospital and neighbouring NHS Trusts (Taylor, MacKenzie, Bowen & Turner, 2012). At 12 months, the TC group demonstrated a 70% reduction in seclusion use whereas the rate of seclusion use increased within the TAU group over the same time period.

The TC group also showed comparatively less clinical pathology over time compared to the TAU group (patients were more likely to internalise rather than externalise problems and present themselves more openly and honestly) (Morrissey, Taylor & Bennett, 2012).

After two years of treatment, the model was evaluated by Morrissey & Taylor (2014) via assessment of PD traits, maladaptive relational schemas, clinician-rated psychopathy and use of seclusion pre-treatment after two years. While no changes were noted in psychopathic traits, significant reductions ($p<0.05$) were found in maladaptive schemas (entitlement, defectiveness, emotional inhibition and vulnerability) and PD pathology (antisocial, schizoid and paranoid traits). Mean seclusion hours had also reduced by 90% within the final six months of treatment. While measures indicating therapeutic change had not been validated for use with a mild LD population, the dramatic reduction in seclusion use indicates the DTC method may hold therapeutic potential for mild LD populations with severe PD pathology in high secure settings.

A further study undertaken by Taylor & Trout (2013) explored the experiences of nursing staff supporting the provision of an LDTC treatment environment within the high secure hospital. Thematic analysis of focus groups and repeated measures EssenCES (The Essen Climate Evaluation Schema – a measure of social climate) revealed staff members had reaped a number of benefits in working within the DTC model, including improved relationships with patients, increased insight into patients' risk factors and enhanced team working (Taylor & Trout, 2013).

Crowther & Clayton (2013) utilised a similar approach in the treatment of individuals with LD and PD within low and medium secure settings. However, a Cognitive Analytic Therapy (CAT) model was adopted as opposed to Schema Therapy to treat relational difficulties associated with PD. A recent evaluation of the service took place within a low secure setting for males with a dual diagnosis of LD and PD (Crowther et al., 2013).

Outcome measures of aggressive episodes (verbal, physical, damage to property) were assessed one year prior to admission and compared with aggressive episodes recorded after one year of treatment. Results indicated a 20% reduction in instances of aggression after 12 months of treatment. Qualitative information garnered from discussions in community meetings suggested patients harboured increased skills in perspective taking, negotiation and compromise which they had begun to apply to the community environment (Taylor, Crowther & Bryant, 2015).

While the evidence base for TC treatment within forensic LD populations remains limited at present, the research literature available provides promising signs around the potential for both staff and forensic LD populations with interpersonal difficulties to benefit from a DTC culture operating within the confines of secure settings.

1.5.2 A critique of TCs

It has been alleged TCs do not provide anything over and above other treatment settings (Lees, 2004; Shuker, 2010), and that when a group of people gather for an extended period of time to develop relationships and a group identity, basic principles of a TC can be applied (Norton & Bloom, 2004). However, results from empirical evidence discussed above suggest TCs deliver superior treatment outcomes when compared to general inpatient treatment/prison settings such as reduced personality pathology and risk of reoffending. Subsequently, this empirical data indicates existence of factors specific to TCs that remain accountable for differences in treatment outcome.

An answer for differences in treatment outcome between general inpatient and TC settings may reside in the traditional model of healthcare often implemented on mental health wards, where caring is interpreted and applied as an activity done by professionals to patients (Norton, 2004).

Use of such a model acts as a barrier to facilitating a TC culture, which, in opposition, promotes individuals' active engagement and responsibility for their care and treatment (Campling, 2001). The promotion of responsibility within TCs maps on to key curative factors (discussed further below) of mastery and confrontation of difficulties (Weinberger & Rasco, 2007).

Consequently, in contrast to general inpatient/prison settings, there is a conscious effort of engendering factors known to increase positive treatment outcome within a TC environment (e.g. involvement in decision making, promoting curiosity and questioning of others) and removal of barriers (e.g. hierarchy, dependency on professionals for care – 1:1 therapy) that prevent their enactment (Campling, 2001). In consideration of the above issues, it appears TCs can be differentiated from general inpatient wards, both on the basis of treatment outcomes and clinical practice.

1.5.3 Utility of TCs in LD inpatient forensic environments

In recent years, inpatient provision for LD populations has dramatically reduced after previous cases of institutional abuse within residential settings sparked a review of national legislation (NHS England, 2015; Taylor, Crowther & Bryant, 2015). Inpatient treatment was no longer deemed appropriate for an LD population by the Department of Health (2012), even when delivered within a professional and ethical context. Consequently, a number of assessment and treatment inpatient services for individuals presenting with behaviour that challenges and/or mental health problems were closed and replaced with increased support within the community to promote independence and community inclusion (Department of Health, 2012; NHS England, 2015).

However, limited consideration was given to the level of care required by individuals who pose a risk to themselves or others, such as individuals with a forensic history, due to mental health difficulties or other unrelated reasons.

Consequently, a faculty report was submitted by the RCOP (2013) to communicate the on-going need for an inpatient pathway for individuals with an LD and mental health problems in such instances where risk posed by an individual's behaviour is of a level that cannot be managed safely within the community.

Unfortunately, the characteristics of inpatient settings for individuals with LD and complex needs were not delineated. In the cultural crisis that comprises modern healthcare epitomised in the dissolution of Mid Stafford Trust, the TC model provides a safe environment by encouraging staff and patients to face their reality; avoiding secrets and hierarchical decision making; encouraging transparency and responsibility to uphold rules and to engage regularly with individuals and the wider organisation (Campling, 2015, p. 23).

With core practices within a DTC promoting patients and their peers as experts, shared decision making and reflective practice within staff teams these components provide a solid platform upon which patient-centred care can be delivered within inpatient services for LD populations and particularly within forensic contexts (Taylor, Crowther & Bryant, 2015).

1.6 Problems of measurement

Although an abundance of research suggestive of DTC efficacy has been developed (Haigh, 2002), the literature accumulated has yet to reach the level necessary for positivist paradigm of research currently adopted. The weight of research findings has been weakened by a number of methodological limitations such as absence or reduced time of follow up periods, attrition, limited use of randomization and establishing a suitable control group (Lees et al., 1999; Warren et al., 2003).

Other complex issues have included heterogeneity within research samples, treatments offered, in addition to on-going modifications to the DTC model. Each of these factors has placed limitations on the measurement and standardisation of DTC treatment. The latter two points have important implications for future research on TCs and will be discussed in turn below.

1.6.1 Heterogeneity within treatments offered

TCs are multifaceted systems and have been described as one of most complex interventions in psychiatry (Rutter & Tyrer, 2003). While work within TCs was originally described in relation to psychodynamic principles emphasising exploration of early attachment, emotional experiences and unconscious processes, over time, TCs have evolved to draw on a range of theoretical models in practice to meet complexity of individuals' needs (Shuker, 2010). Thinking around theoretical processes inherent within forensic TCs has expanded to include social learning, and cognitive behavioural processes, as opposed to purely psychodynamic factors (Shuker, 2010).

Within forensic TCs, individuals are described to engage in reality testing of beliefs and assumptions about others within the TC and have these explored and challenged by TC members. Social learning is also thought to occur through observation of peers and staff modelling prosocial behaviours supporting individuals to learn alternative ways of being (Shuker, 2010).

While community based TCs may incorporate individual therapy in addition to group therapy, within forensic TCs therapy is largely delivered in large and smaller group formats. For example, therapy models (CBT, Schema therapy, CAT) adopted at Dovegate TC, and the LDTC based in the high secure hospital of focus in this research, are generally delivered in a group format (Taylor & Morrissey, 2012; Crowther & Clayton, 2013). Additional offence-focused groups are often implemented to target criminogenic risk factors according to individuals' needs, such as Sex Offender Treatment Programmes (SOTP) and Reasoning and Rehabilitation (R & R) groups (Day & Doyle, 2010).

Over time, some forensic TC programs have evolved to further combine forensic and therapeutic orientated approaches to dually address both clinical and risk treatment needs. The Good Lives Model (GLM) is a prime example of this, which focuses on people's strengths and the development of these via formulation of personal goals (Brookes, 2010).

Other forensic TCs (e.g. HMP Gartree TC, TC+, HMP Dovegate, TC, TC+) have welcomed integration of more creative group psychotherapies including Art and Music therapy (NHS England & NOMS, 2015). The range of treatments provided within TCs and the differing format in which they are delivered has made it difficult to quantify efficacy between and across TCs, as each system is so very different. Furthermore, the plurality of therapeutic techniques within more general TC work has prevented clear articulation and definition of TC work in comparison to other forensic treatment models (Shine & Morris, 2000).

1.6.2 Modifications

The nature of forensic environments has necessitated the adaptation of a number of fundamental TC principles (discussed further below). The principle of democracy has been notably compromised - individuals are unable to exercise freedom of choice to leave as they choose, and decisions regarding eligibility for treatment generally rest with practitioners to ensure the safety of patients and staff (Polden, 2010). Further modifications have been made for populations considered to have dangerous and severe PDs (Shine, 2010). Within Millfields medium secure unit, a number of adaptations made to the original DTC model, including pharmacological treatment and a range of psychological therapies dependent on individuals' criminogenic history and psychological needs (Shine, 2010).

Other minor adaptations have been made in forensic LD TC settings, such as symbolised minutes to community meetings, increased use of pictorial communication, shortened meeting times, and speech and language therapy support (Morrissey, Taylor & Bennnett, 2012).

Therapy is completed at a slower pace, within smaller groups and content is further structured, such that a specific theme for discussion is chosen each time to address treatment need in an identified area (Dovegate TC +, Gartree TC +) (NHS Englands & NOMS, 2015).

Service integration has also been known to impact on forensic TCs in a number of ways. The majority of forensic TCs have been integrated into larger prisons/hospitals and therefore remained bound by security rules and regulations of wider systems that may be at odds with the TC ethos (Rawlings, 2005). Cullen & Miller (2010) have reflected on how the TC philosophy is at stark odds with prison regime and the consequent impact of this on the development of Dovegate TC in its early years. For example, limited financial and emotional support was provided compared to that received by others services in the prison and the TC was generally held in low esteem by surrounding staff and management teams.

In light of suspicions held by the efficacy of the TC, the community was also hampered by continual investigation for malpractice. As the LDTC within a high secure setting is a relatively new service (5 years old), it will remain important to bear in mind the effects of clashing of philosophies between the TC and overall hospital as well as potential effects on the service, staff and wider community morale.

This issue may be particularly pertinent, as the high security status of a high secure hospital requires the LDTC to adhere to additional security restrictions. For example, only a certain number of patients are allowed out of their residing unit at any given time and in the event of an incident the entire hospital is locked down. Such restrictions imposed in specialist hospitals inevitably impact on timetabling and TC culture (Rawlings, 2005).

Despite varying modifications across forensic TCs, there are a number of common elements that have informed a TC accreditation process to regulate and improve quality among TCs (Haigh & Tucker, 2004).

The accreditation process was developed by the Community of Communities in partnership with the RCOP to provide a quality assurance network to measure standards of good practice against agreed TC principles amongst other methods and features of the LDTC of focus in this research is working toward achieving this accreditation and making good progress as indicated by a recent review in February 2015 (Community of Communities, 2015).

1.6.3 Implications for future TC research designs

Measurement difficulties within TC research require attention for the treatment modality's full utility to be realised (Shuker, 2010). Previous arguments have suggested flaws within outcome studies are the product of attempting to place TCs within a positivist research paradigm, when they are in fact incompatible with this epistemological position (Haigh, 2014). As Haigh (2014, p.75) aptly points out, TCs are 'a place where strict definition becomes impossible, and where operationalization and manualisation could only ever cover a fraction of the essence'.

On this basis, suggestions have been made to complete TC research according to differing research paradigm. A number of researchers have called for a more explorative approach to appreciate the varied mechanisms within a TC and build an evidence based understanding of processes inherent within contributing to a social climate conducive to therapeutic change (Aslan & Yates, 2015; Magor-Blatch, Bhullar, Thomson & Thornsteinsson, 2014; Veale, Gilbert, Wheatley & Naismith, 2014). Such an understanding could inform what treatments can be appropriately added without undermining the central integrity of the approach (Aslan & Yates, 2015).

The values within a therapeutic environment have long been considered of great importance in respect to the foundational social climate they provide from which therapeutic change might blossom (Almond, Keniston & Boltax, 1969). However, the extent to which a treatment unit's values influence behaviour and eventual outcome have remained an unanswered albeit important question.

Research by Almond et al. (1969) suggests while value change follows rather than precedes behavioural change, values of therapeutic environments (valuing patient membership in the hospital community, encouraging openness of communication, patients' confrontation of problems and acceptance of responsibility) result in a shared patient-staff culture providing the necessary conditions in which changes in behaviour become possible. A number of theories that have been in pursuit of establishing an understanding of principles contributing to effective therapeutic climates are discussed below.

1.7 Key Theoretical Foundations

TCs have evolved from a number of different schools of thought, including an amalgamation of theories from sociological theory, systems theory, and psychoanalytic concepts (Clark, 1965). It is beyond the scope of this review to discuss these theoretical orientations in detail. Therefore, specific theories derived from these schools of thought to delineate core features within therapeutic environments (PIPES, PIEs, DTCs) are reviewed. Theories based on the TC approach and TC proper are considered due to DTCs having firm theoretical roots within the TC approach.

A common factors approach to psychotherapy is also considered due to their direct and empirically evidenced relevance in supporting a climate conducive to change in all forms of therapy. Key theories are considered in turn below.

1.7.1 Curative Factors in Psychotherapy

The common factors argument posits a large proportion of improvement post psychotherapy can be attributed to common factors, rather than specific techniques utilised in distinct forms of psychotherapy (Wampold, 2015). In 1936, Rosenzweig conducted a review of the literature and highlighted all therapies to have four common factors; a therapeutic relationship, a systematic rationale to explain individuals' presenting difficulties along with a means of addressing them, an effort to integrate personality systems and finally the personality of the therapist.

On the basis on these results, the ‘Dodo verdict’ was made – “everyone [all psychotherapies] has won and all must have prizes” (Luborsky, 1975). A recent analysis of change factors suggested the following allocation in regard to domains responsible for client outcome: common factors (alliance and relationship variables) 35%, therapist effects 20%, specific techniques at 5% and the remaining 40% held by extra-therapeutic sources (client characteristics, environmental factors e.g. social support) (Lambert, 2008).

Contemporary thinking on common factors of therapy suggests the following concepts remain important curative factors in psychotherapy (Wampold, 2015). Alliance can be defined as bond, agreement on the goals of therapy and therapeutic tasks (Bordin, 1979). A recent meta-analysis including 200 studies and 14,000 clients demonstrated a medium effect size of $d=0.57$ between alliance and clinical outcome (Horvath, Del, Re & Fluckiger et al., 2011). Other research has also highlighted the importance of the ‘real relationship’ – a relationship that is genuine and transference free (Wampold, 2015, p. 273), and its relationship to outcomes (Gelso, 2014). Therapist empathy has also been shown to have moderate effects on clinical outcomes ($d= 0.63$) (Elliott, Bohart, Watson & Greenberg, 2011).

The ability of the therapist to be attuned to, share and identify with the emotional experience of another remains necessary for goal sharing and the regulation of social interaction (Wampold, 2015).

Thirdly, client expectations of therapy have been shown to have a small but statistically significant relationship as indicated in a meta-analysis comparing client ratings and outcome ($d=0.24$; Constantino, Arnkoff, Glass, Ametrano & Smith, 2011). Finally, therapist effects have also been shown to have implications for clinical outcomes regardless of client group or treatment approach ($d=0.55$; Baldwin & Imel, 2013). Generally, therapists with increased interpersonal skills, the ability to form stronger alliances and increased expression of professional self-doubt are likelier to achieve greater clinical outcomes for the individuals they work with (Wampold, 2015).

Similar to Wampold (2015), Weinberger & Rasco (2007) emphasise the therapeutic relationship and client expectations of treatment efficacy as important common factors for change. However, three further empirically supported factors are highlighted, including confrontation/facing problems (e.g. facing rather than avoiding anxiety via exposure to fears), mastery/control experiences (enhancing a sense of cognitive control), and patient attributes of successful outcome to internal/external causes.

With regards to the latter factor, patients who attribute progress during treatment to internal attributions (e.g. increased coping skills) are less likely to relapse in future, whereas those who attribute change to external causes (e.g. having a wonderful therapist) are less likely to maintain improvements made post therapy.

1.7.2 Social environments

Moos & Moos (1976) have conducted extensive work into the personality of social environments and the processes and mechanisms within them that support change. In sum, it is proposed the social climate of any given setting, be it educational, clinical or occupational, can be divided into three dimensions; quality of interpersonal relationships (individuals' involvement in the environment, level of support provided to each other, free and open exchange of ideas and sense of cohesiveness amongst members), mechanisms for system maintenance and change (extent to which environment is orderly, clear in terms of expectations of behaviour, how consistently boundaries are enforced and ensuing consequences, innovation; encouragement of creative thinking) and opportunities for personal growth (opportunities to gain independence, partake in competition and pursue autonomy; freedom to make own decisions) (Moos & Moos, 1976).

More recently, Moos (2012) has extended his conceptualisations of social environments to account for interactions between physical and architectural (facility location, space availability, community accessibility, social-recreational aids), policy and program (expectations/regulations for behaviour, organisational structure), resident and staff resources (social backgrounds, functional abilities, characteristics), and their mediating influence on social environment resources (interpersonal relationships, mechanisms for system maintenance and change; opportunities for resident influence, opportunities for personal growth; independence, self-exploration).

The model suggests any given organisation itself can affect the social climate directly by the nature of the setting. Moos (2012) provides a comparison of a hospital with a community based facility, suggesting the latter to generally harbour increased flexibility and choice in the implementation of policies/programs in comparison to hospitals, enhancing organisation and resident involvement, impacting on staff/resident characteristics (attract better trained staff and more functionally able residents able to develop more independence-orientated environments).

An instrument was created to test these four core domains, titled the Multiphasic Environmental Assessment Procedure (MEAP) which has been implemented across 93 care homes in California (Moos, 2012). Data collected was used to explore the conceptual model and results suggested all three additionally proposed domains provided unique and combined effects on the environmental social climate (Moos, 2012).

While the model provides a useful conceptual framework for understanding social environments, as Moos (2012) notes, important features of a social climate are likely to vary across settings, particularly specialist establishments with unique physical conditions and policies such as those implemented within a high secure hospital.

1.7.3. Therapeutic Environments

Since 2001, the development of a specific set of national standards and values for TCs has been underway to establish an accreditation process for enabling environments (PIEs/PIPEs) (Kennard & Lees, 2012). The formation of a core set of values involved an amalgamation of both Rapoport's (1960) and Haigh's (2013) principles (discussed below), alongside input from service users and staff members from a range of clinical and non-clinical establishments during an initial consultation process (RCOP, 2015).

The values were developed with the purpose of developing a common language to bridge distinctions between clinical and non-clinical settings to include a range of environments where people come together for a specific purpose (schools, day units, wards, supported accommodation, voluntary groups, faith communities).

The ten enabling environment values have been described as akin to that of ingredients in a recipe for TCs (Haigh, 2015). The core values include the following: Belonging – the nature of quality of relationships are of primary importance; Boundaries – individuals have expectations of behaviour and processes to maintain and review them; Communication – all people are supported to communicate effectively and have opportunities to share feelings behind ways people act; Involvement – all individuals share responsibility for the environment, and Empowerment – power and authority are open to discussion, all bear some resemblance to ground covered by the aforementioned quintessence principles.

Further values include: Development – individuals have opportunities to be spontaneous and try new things; Safety – support is available for everyone, peer support is valued and encouraged; Structure – engagement in purposeful activity is encouraged with a consistent structure or daily routine; Leadership – involves taking responsibility for the environment remaining enabling e.g. by remaining active participants in the life of the community; Openness – relationships outside of the environment are sought and valued e.g. the environment is welcoming to visitors.

The core values adopt a broad-brush approach to encompass the core foundations of TCs, regardless of service user population or setting. Although intended as guidance, focus on these categories occurs at the expense of rich contextual and meaningful information inherent in specialist TC settings (Haigh, 2014).

1.7.4 Democratic Therapeutic Communities

In specific regard to the TC ‘proper’ model, Rapoport (1960), a Sociologist, is documented as one of the first qualitative researchers to investigate processes within a TC via an ethnographic study at the Henderson Hospital, London. Through this research, four principles were identified to describe the core elements of a TC environment leading to the development of therapeutic relationships: Democratisation – a flattened hierarchy, with members sharing equal power in decision making processes; Communalism – curious enquiry into personal difficulties of others; Permissiveness – toleration of others’ behaviour to aid development of self-awareness of maladaptive responses; Reality confrontation – individuals are confronted with interpretations of their behaviour from staff and peers within the TC (Rapoport, 1960). Notably, these principles were solely derived from the perspectives of staff members within the hospital (Debaere et al. 2016).

Haigh (2013) provided an update of the above principles, again utilising his own experiences within clinical practice, and linking this to previous theory theories of milieu therapy, psychoanalytic, systems and attachment theory. The clinical utility of Rapoport's (1960) themes was extended, connecting the above external experiences to psychological processes experienced by individuals to describe the often preverbal process of what it feels like to be in a TC – the emotional experience. Indeed, the emotional climate is thought to transverse and intersect all other therapeutic factors (Vigorelli, 2014).

A developmental model was advocated, whereby the TC setting is described to allow individuals to experience conditions conducive to 'primary emotional development' which were unable to be experienced previously, to enable 'healthy personality formation' (Haigh, 2013: 6). Individuals are thought to progress through five key conditions with some going and froing.

The first is attachment (belonging) – the experience of an emotional and nurturing bond to provide a coherent experience of existence and protect individuals from being overwhelmed by future life events, including loss of attachments. Next follows containment (previously termed permissiveness by Rapoport [1960]), which describes the external holding (boundaries/rules) and validation of extreme feelings of 'boundless distress' so that individuals might experience the world as safe and learn they are able to tolerate difficult experiences.

Edelson (1970) names this as the therapeutic environment maintaining integrity in the face of the service users' 'inner chaos'. The community (peers and staff) provide an 'auxiliary ego' which provides external controls to individuals whose inner controls have not yet developed fully or lapsed. Over time, individuals are then able to distinguish between inner and outer reality, allowing them to create constructive interactions with others (Nativ, 2014).

Communication (previously termed communalism) then ensues, whereby emphasis is placed on more open and honest interactions than that experienced in everyday life leading to the deepening of relationships with others and discovery of personal meaning through interacting with others. Structures that aim to facilitate this stage in a TC include weekly group meetings, expectation of attendance and agreement on boundary issues, alongside inviting visitors in to the community and maintaining transparency in regards to the inner workings of the TC to commissioners/referrers/colleagues.

The fourth stage, involvement and inclusion (previously termed reality confrontation), pertains to a 'culture of participation and citizenship' and is generally seen as the transition from adolescence to adulthood. Social cohesion is the primary aim, whereby responsibilities to self and others create interdependence where individuals become meaningfully defined by social processes. Weekly community meetings are one mechanism by which a sense of togetherness is generated via holding in mind of the week's business by all members.

The fifth and final stage of agency (previously termed democracy) involves the constant negotiation of authority, which is shared equally amongst all community members. Authority is understood to exist between people as opposed to within individuals or policies. Through experiencing authentic relationships (those not defined by authority or rank) a sense of personal agency is able to develop allowing individuals to truly own their actions and feelings (Haigh, 2015).

In consideration of Haigh's (2013) principles, some overlap is evident with Moos & Moos' (1976) conceptualisation of the three dimensions proposed to support change within a given social climate. The involvement and inclusion principle may be understood to fall within the 'Interpersonal' dimension, which emphasises involvement of individuals and developing a sense of cohesiveness in the environment.

One could also argue communication falls in to this dimension with respect to individuals being supported to freely exchange ideas between one another. The principle of containment shares similarities with the dimension on 'mechanisms for system maintenance' with its focus on boundaries and their implementation. However, a specific behavioural focus is taken within this dimension in terms of external 'holding' via rule implementation, and the emotional component (validation of extreme distress) of containment Haigh (2013) describes remains absent. Limited focus on the emotional component of social environments is also exemplified in the lack of explicit discussion on attachment within the interpersonal dimension of Moos & Moos' (1976) conceptualisation of social climates.

The final principle of agency can easily be subsumed under the dimension of 'opportunities for personal growth' with respect to its emphasis on the environment facilitating opportunities for residents to gain independence and make their own decisions. Contrastingly, however, agency is emphasised by Haigh (2013) as an interpersonal process, and something that is shared and 'negotiated' by a community, versus individuals making decisions independently. In order to facilitate this, a deliberate move to dismantle and equalise 'staff' and 'patient' hierarchy is highlighted, which is not acknowledged within Moos & Moos (1976) conceptualisation of social environments.

Haigh's (2013) quintessence principles have been discussed at further length by Pearce & Pickard (2012). After conducting a focused literature review, the authors concluded it is the combination, extent and emphasis of principles of belongingness and responsible agency that differentiate TCs from other forms of psychotherapy. TCs are hypothesised as uniquely placed to combine concepts of belongingness and responsible agency, due to the strength of the nurturing and caring environment, motivating people to develop behavioural change independently, and provide protection from judgement through compassion when difficulties are experienced.

Both Haigh's (2013) and Rapoport's (1960) theories comprise the core theoretical background of therapeutic communities and accreditation process regulated by the RCOP, although have yet to be subject to empirical verification in contemporary TC settings.

Papers published in this area have tended to offer therapist reflections on processes evident within community/secure TCs (e.g. Nativ, 2014; Polden, 2010). While setting out to explore how unstructured time within TCs leads to therapeutic change, ethnographic research by Clarke (2015) identified limits to agency in two community TCs (one residential and one day community) in the U.K. Clarke (2015) identified while individuals spoke of a flattened hierarchy existing, differences in power were evident between less and more experienced TC members and service users and staff. However, differences in power were not always construed negatively (e.g. staff exercising authority to contain powerful negative emotions experienced by service users was considered helpful), and in many ways power hierarchies were fluid and open to change rather than flattened.

Grey service evaluation literature exists in the form of focus groups completed with LDTC nursing staff and service users, exploring views on the general therapeutic environment and practices (Morrissey & Bennett, 2012). While the data has alluded to confirmation of elements of existing theory on TCs and therapeutic environments, the data analysis remains unpublished, preventing the explication of valuable conclusions. Ultimately, this has prevented empirical investigation of existing and additional TC features experienced by service users in addition to their value in promoting a supportive environment.

1.8 Rationale for the study

In summary, existing theory providing the core theoretical background for TC environments (Rapoport [1960], Haigh [2013]) has largely developed from a practitioner perspective, avoided subjection to empirical testing and maintained a generic focus despite the heterogeneous implementation of TCs in complex and specialist forensic settings.

Although the novel LDTC located in one of three high secure hospitals in the U.K., has been evidenced to improve interpersonal difficulties and incidents of physical aggression, current research and theory is unable to specifically imply whether suggested theoretical processes exist in this community or their respective importance to TC members (staff and service users) in facilitating a supportive therapeutic environment within this novel modified treatment setting. Investigation of this area would further develop the evidence base for theoretical knowledge in this niche setting, in addition to wider TC theory and therapeutically inform the environments of TCs for a forensic LD populations within high secure services.

1.8.1 Aims and objectives

The purpose of this study is to investigate TC members' evaluations of therapeutic community principles within an LDTC based in conditions of high security.

PRIMARY OBJECTIVE

The main aims of this study are to:

1. Explore both service user and staff members' evaluations of TC principles as outlined by Haigh (2013) and identify whether these are present in the environment of the LDTC.
2. Identify whether any further important principles exist within the social climate of the LDTC that are not captured by current TC theory.

2. Extended Methods and Results

2.1 Overview

This section details the qualitative design of the study, which involved a deductive content analysis (Mayring, 2000) and thematic analysis (Braun & Clarke, 2007), (detailed in the journal paper). Main results from the deductive content analysis and thematic analysis were presented in the journal paper. Additional results from both analyses are included in the extended results section.

The rationale for the study design and philosophical assumptions underpinning the research are described. Ethical issues are then considered related to the research. An extended discussion is then provided on the qualitative results presented in the journal paper. The development of the interview schedule is detailed alongside recruitment and data collection methods. Finally, actions taken to ensure quality and trustworthiness of the research are detailed.

2.2 Study design

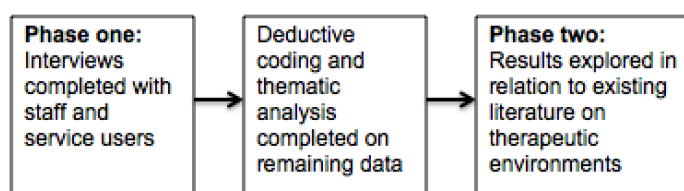
TC principles have largely been developed by practitioners, maintained a generic focus and not been subject to empirical testing despite the implementation of TCs within varied and complex forensic settings. Consequently, a single case study design was considered most appropriate to investigate key TC principles within a high secure LDTC and their value to respective TC members in depth. Thomas (2011:138) defines the single case as 'studied for the lineaments of its structure, its character, with the emphasis on understanding what is going on'.

The LDTC at one of three High Secure Hospital's in the U.K. was selected for independent focus due to the unique and novel nature of this setting. Selection of a case on this basis is known as an 'outlier', selected on the basis of its stark differentiation from normality (Thomas, 2011:92).

The purpose of the single case study was exploratory, as the research aimed to investigate principles (as outlined by Haigh, 2013), alongside any additional principles in the environment of the LDTC experienced by its members. The approach of the research was dual, in that it aimed to test existing theory on therapeutic processes within a TC, while also building on existing theory by exploring whether additional material exists unaccounted for within the current theory.

In light of limited qualitative studies on TC members' perspectives on TC principles, a qualitative exploration was considered most appropriate to explore staff and particularly service users' perceptions of TC principles with a unique and novel population.

Figure 2: Qualitative single case study procedure



Qualitative methodology can be considered exploratory in nature, utilising methods (e.g. focus groups, interviews) to gain rich and detailed descriptions of individuals' experiences and processes (Madill, Jordan & Shirley, 2000). The collection and analysis of often-textual data aims to explore phenomena in the context in which they occur, focusing on induction, discovery, exploration and theory/hypothesis generation (Bendassolli, 2013). Conversely, the major characteristics of quantitative research reside upon prediction, explanation, theory/hypothesis testing and statistical analysis, in the aim of generating objective and generaliseable knowledge (Johnson & Onwuegbuzie, 2004). However, a focus on the above elements often occurs at the expense of consideration of individual experiences and contextual factors.

Even so, some drawbacks exist in relation to qualitative research. For example, qualitative research has often been criticised for being influenced by the researcher's personal biases (Johnson & Onwuegbuzie, 2004). Despite this, qualitative methodology is being increasingly accepted as a legitimate means of enquiry (Ospina, 2004). Ultimately, it was concluded a qualitative approach outweighed possible drawbacks, as the aims of the research were best met by such an approach. Given that TC principles have not been subject to empirical testing within actual TC environments, adopting a qualitative approach was considered necessary to explore both staff and service users' experiences of TC principles and possible additional features within the novel environment of the LDTC.

2.3 Research project or audit?

At first glimpse, the research may appear to be audit like in design. As Haigh's (2013) TC principles were developed from clinical observations and not empirically validated, this research represents the first attempt of testing Haigh's (2013) TC principles empirically in one particular (and quite unique) TC setting – a high secure LDTC. Arguably, the TC principles are being tested under the most unfavourable conditions (secure environment, LD population). The research goes beyond confirming/disconfirming the presence of TC principles in the LDTC as it also aims to explore nuances in how TC principles are experienced by service users and staff members alike. The research also attempts to build on Haigh's (2013) theory by exploring whether further principles are evident in the environment of the LDTC. Consequently, the research goes beyond the aims of an audit, which specifically seeks to identify whether a service reaches a specified standard or standards (Avon Primary Care Research Collaborative [APCRC], 2016).

2.4 Philosophical assumptions

Qualitative and quantitative approaches to research are underpinned by differing philosophical assumptions in regard to how we come to know reality (epistemology) and the nature of reality (ontology) (Scotland, 2012). Qualitative approaches have placed specific emphasis on the human interpretation of the social world, and are traditionally associated with interpretivist assumptions suggesting there to be multiple realities as opposed to one knowable world (Richie, Lewis, Nicholls & Ormston, 2013). Consequently, generalization of results is not an aim of such research. Instead, both the participant and researcher's interpretations and understanding of the phenomena being studied are considered, with the primary aim being to understand each individual's lived experience (McEvoy & Richards, 2006). This view challenges traditional distinctions between ontology and epistemology, as the nature of reality and knowledge is considered as interwoven in a dynamic process of mutual co-determinism (Richie, Lewis, Nicholls & Ormston, 2013).

On the other hand, quantitative approaches have been traditionally associated with a positivist or post-positivist stance (Yang, Lee & Tzeng, 2008). From this perspective, it is postulated a real world exists independent from ourselves and consequently knowledge can be objective and 'true' providing subjective biases and perspectives are controlled for (Carlo & Gelo, 2012). From this stance, the aim is to explain, predict, and control phenomena regarding cause and effect relationships (Creswell, 2009). This is often achieved via employment of experimental designs, broad and representative samples, in addition to use of inferential statistics enabling testing of hypotheses regarding relationships between variables.

2.5 Epistemological stance of the researcher

Critical realism has attracted significant interest in the last few years (Easton, 2010; McEvoy & Richards, 2006). Established in the writings of Bhaskar (1975), critical realism arose from the critique of naïve realism leveled at positivists in respect to the assumption knowledge and reality can be captured in context free form. The stance is seen as a mid-way position between positivism and interpretivism, integrating a realist ontology with an interpretivist epistemology, positing a real world exists harbouring regularities, although the certainty with which we may identify these is complicated by the socially constructed nature of our experience (Barker, Pistrang & Elliott, 2002). Rather than identifying generaliseable laws or seeking to understand individually lived experiences, critical realism engages in retrodution – a process which seeks to develop a deeper understanding of phenomena under study by initially focusing on individual experiences before moving backward to focus on underlying processes (Lipscomb, 2012).

The current aim of this research was to gain a more in-depth understanding of TC members' evaluations of existing TC principles within a high secure LDTC alongside exploration of any additional principles unaccounted for by current theory. Consequently, a critical realist perspective was adopted.

This seemed particularly appropriate in light of current literature on principles inherent in TC environments (discussed in section 1.7.4), which suggest while there are widely varied forms of TCs in terms of therapeutic setting and target client population, there are a number of shared principles within the environment, suggesting some common processes. A single case study comprising of a qualitative design seemed well suited to a critical realist position as, it reflects the initial process of retrodution – beginning with a qualitative focus on TC members' perceptions of TC principles, with the aim of future research utilizing this data to move toward quantitative exploration of common underlying processes.

2.6 Ethical approval

The study was reviewed and approved by Lincoln University's Ethics Committee (See Appendix A) and subsequently Leicester Central NHS Research Ethics Committee (See Appendix C). The study was also discussed with the head of LD services at the high security hospital that supported the research and agreed to facilitate recruitment. The ethical issues of the British Psychological Society (BPS, 2009) were adhered to throughout the study, and the most pertinent aspects are presented below.

2.7 Privacy and confidentiality

Audio recordings of interviews were transferred on to a secure hospital computer and erased from the recorder. Prior to transcription by a secretary with existing access to clinical data, each participant was assigned a pseudonym. Preceding transcription, the transcriber signed a confidentiality agreement in line with university procedures and data protection policies of the hospital

The only personal data collected was in the form of consent forms, containing a unique identifier for each participant, linking them to their transcript. Consent forms and transcripts were stored securely in a locked filing cabinet during the study and destroyed upon completion of the research, in line with the High Security Hospital's data protection policy. Only analysed data was transported from the hospital and stored in a secure office at the University of Lincoln after study completion. All analysed research data will be stored for seven years after completion of the study and then destroyed securely.

2.8 Informed consent

All participants were fully informed as to the nature of the research and were provided with an information sheet regarding the study. They were given at least 24 hours to consider whether to take part and offered the opportunity to ask questions. Participants who chose to engage were asked to sign a consent form prior to completing either stage.

2.9 Withdrawal from study

Throughout the research, it was emphasised participation remained voluntary and that withdrawal would not affect individuals' future care or employment. Participants were made aware they were free to withdraw from the interview and retained the option of withdrawing their data up to one week after engaging in the interview by contacting the researcher.

Service users were able to remove their data by requesting a member of staff to contact the researcher via email with their ID code (as detailed in the information sheet and consent form located in the client's clinical notes). Staff members were able to withdraw their information by contacting the researcher via the email address provided. None of the participants chose to withdraw their data.

2.10 Protection of participants

As interviews involved the discussion of personal experiences, it was possible participants may have found topics discussed distressing in nature. As a Trainee Clinical Psychologist, the researcher was well resourced to contain and manage any distress that arose. Should a participant have requested assistance beyond the researcher's line of work or required additional support they would have been referred to appropriate services. However, none of the participants became distressed during interviews or requested further support.

2.11 Debriefing of research participants

All participants were debriefed after taking part in the study. Staff members were provided with the researcher's contact details in case they wished to make contact at a later time. Staff members were able to make contact with the researcher on behalf of service users, should they wish to discuss a research-related matter. Upon completion of the research, results of the study were presented to TC members within the LDTC. A written summary of the results was also provided.

2.12 Qualitative methods

2.13 Rationale for qualitative methods

The research explored TC members' perceptions of TC principles. This was required as previously theorised TC principles have not been subject to empirical investigation with those who reside in the environment. Two specific methods were selected - qualitative deductive content analysis and thematic analysis. Both are qualitative approaches considered independent of theoretical assumptions and can thus be utilised in frameworks such as critical realism (Braun & Clarke, 2006; Mayring, 2000).

Qualitative content analysis involves the subjective interpretation of content of text data and its contextual meaning via systematic classification process of coding and identification of patterns (Hsieh & Shannon, 2005). While quantitative analysis also involves coding of data, codes are then described via use of statistics (e.g. frequencies) to undertake quantitative analysis of quantitative data (Hsieh & Shannon, 2005). Qualitative content analysis can be completed either inductively or deductively. An inductive approach is generally used when there is limited existing knowledge in regard to a phenomenon.

Categories are derived from the data where particular instances are frequently observed and combined into a larger whole or general statement (Elo & Kynga, 2007). Qualitative deductive content analysis, on the other hand, is a method of assigning pre-fixed categories to text based on previous theory/knowledge to test and expand existing theory (Mayring, 2000). When the purpose of the study is to build upon theory, the word concept rather than category is used (Elo & Kynga, 2007).

Content analysis has been commended for offering a content-sensitive method, which may be flexibly employed in a variety of research designs (Elo & Kynga, 2007). However, there are no systematic rules in regard to the analysis of data. Consequently, description of analysis can prove difficult, as the researchers own actions and insights are difficult to capture in words (Hsieh & Shannon, 2005).

Thematic analysis is a method of identifying patterns or themes within data and can be accomplished either inductively or deductively (Braun & Clarke, 2006). An inductive approach is data-driven, where themes are derived from the data without searching for pre-existing evidence or ideas. Unlike inductive content analysis, inductive thematic analysis determines the significance of themes on whether they capture something important to the research question (Boyatzis, 1998), as opposed to the frequency in which themes/categories occur (Hsieh & Shannon, 2005). A deductive approach is driven by the researcher's theoretical interests and involves detailed analysis of some aspect of the data.

Such an approach is most often used when coding for a specific research question, where as within an inductive thematic analysis, the specific research question may evolve through the coding process (Braun & Clarke, 2006). Unlike deductive content analysis, initial codes can be expanded or deleted during the coding process in order to gain a representative picture of the data (Fereday & Muir-Cochrane, 2006).

While the theoretical flexibility of thematic analysis remains appealing to researchers, this does not mean the approach is theory free. On the contrary, the theoretical framework and underlying assumptions within which the method is used require consideration (Braun & Clarke, 2006).

As this was the first study to evaluate TC principles in a unique TC setting, a deductive content analysis was considered most appropriate for initial analysis. When using deductive content analysis, there is a strong propensity for researchers to find evidence supportive rather than nonsupportive of an existing theory (Hsieh & Shannon, 2005). Consequently, comprehensive coding instructions containing the process and rules for data analysis will be utilised to demonstrate transparency within the process of analysis. A colleague external to the research utilised the coding scheme to code a test piece of data after which ratings were compared to test reliability of the coding scheme. An inductive thematic analysis was selected for secondary analysis to identify any significant themes within the remaining data that captured important aspects unable to be accounted for by existing TC principles.

A completely inductive approach can be difficult to achieve as researchers have an existing understanding of the research area based on existing literature and expectations of the data. Currently, a variety of theories exist in relation to key components that constitute therapeutic environments. Therefore a deductive approach was also used when linking research findings to wider literature to acknowledge other existing theories in the area.

Other qualitative approaches were considered for the initial and secondary analysis, particularly grounded theory. Grounded theory is an inductive approach aiming to develop a theoretical understanding of a phenomenon from data, versus beginning with a theory (Tweed & Charmaz, 2012). Similar to content and thematic analysis, grounded theory is not necessarily wedded to an epistemological position.

Grounded theory is seen as both a research method, offering guidelines on identification of categories in data and integrating these and also an outcome of a research study due its generation of a grounded theory (Cho & Lee, 2014). The method is therefore most usefully used when there is limited research within a given area.

Glaser & Strauss (1967) published the first initial paper on grounded theory and brought unique and different assumptions to grounded theory, resulting in alternative forms of the method. While Glaser (1992) suggested an inductive approach, with themes emerging from the data without the researcher imposing apriori ideas or assumptions, Strauss (Strauss & Corbin, 1990) took a more deductive stance to analysis, allowing for more flexibility in acknowledging existing theories. Consequently, depending on the way in which grounded theory is utilised the method operates on an epistemological continuum from more positivist forms (Glaser, 1992), to post-positivist (Strauss & Corbin, 1990) and more recently constructivist versions (Charmaz, 2006). The latter version falls within a social interaction approach where the researcher becomes involved and interacts with participants in constructing theory.

As there are existing theories on TC principles and research on therapeutic components of environments, Strauss & Corbin's (1990) approach may have been most suitable, allowing for a combination of inductive and deductive analysis. However, the aim of the research was to evaluate TC principles on the basis of experiences of TC members and build upon these via identification of additional important themes, if any, that existing principles are unable to account for. This lies in contrast with the aim of developing a new theory. Consequently, a deductive content analysis and inductive thematic analysis were selected as most appropriate.

Use of template analysis was also considered (Waring & Wainwright, 2008). This method is said to have emerged from structured approaches such as grounded theory. When utilising this method, a codebook is developed, including 'a priori' codes based on previous theory/knowledge.

While research may begin with exploring the data and applying these codes where relevant, these are refined and modified during the analysis process (Crabtree & Miller, 1999).

This remains similar to a deductive thematic analysis. However, as TC principles have not been empirically tested before, it was preferable to specifically test existing principles via application of representative categories where relevant, as opposed to modifying, adapting and deleting codes during analysis. This would facilitate increased clarity as to the applicability of TC principles to the LDTC and whether additional key aspects exist that are currently unaccounted for by current theory.

2.14 Development of interview schedule

Semi-structured interviews were used to collect the data. Interviews were selected for two reasons. For service users, this was considered the most appropriate method to gain more in depth and rich data. In light of service users' diagnoses of mild to moderate learning disabilities, the process of a focus group may have been hard to track. Further, service users may have been influenced by others' answers, affecting the credibility of data (Baxter, 2005).

For staff, interviews were considered most appropriate primarily due to practical reasons in that these needed to be arranged around work commitments. It was consequently not feasible to arrange for a number of staff to attend a focus group together due to individual timings of lunch breaks and changing shift patterns.

A semi-structured format was chosen for interviews to allow flexibility for questioning, in comparison to a structured interview. This allowed for modification of initial questions in light of participants' answers. Unlike an unstructured interview, this also facilitated exploration of interesting areas in more detail while maintaining a focus on the area of significance.

The semi-structured interview started with some specific questions about TC principles to facilitate a discussion on areas detailed in existing theory (reported by Haigh, 2013 – discussed in the ‘background’ section).

TC principles are notoriously difficult to capture as they refer to pre-verbal experiences associated with emotionally lived experience (R. Haigh, personal communication, 2015). Interview questions were therefore refined via discussions with clinicians who had previously worked or resided in TCs and were consequently familiar with the philosophy and experiences within such establishments. Thereafter, a number of broader questions were asked to elicit participants’ views on any additional experiences in the LDTC that remain uncounted for by current theory.

2.14.1 Suggestibility

It is well known that individuals with a diagnosis of a learning disability may be more suggestible when posed with leading questions (Gudjonsson & Henry, 2010). Consequently, every effort was made to protect against influencing service users in providing specific answers. For example, to increase accessibility of questions and maintain neutrality, service user interview schedules were refined by a voluntary charity group of individuals with learning disabilities and their carers. Two Clinical Psychologists experienced in working with individuals with mild to moderate learning disabilities were also consulted in the phrasing of questions within the interview schedule to maintain neutrality of questions posed.

In addition, while half the interview was focused on identifying whether TC principles were present in the LDTC, the remaining half of the interview utilised questions to enable service users to use their own language in describing other alternative experiences in the TC. For example, ‘If your TC were an animal, what would it look like?’ When conducting the interview with service users, a number of additional prompts were used.

After initially presenting the first open question, follow up questions (in an either/or format) were used to support the individual in answering the question, if required, without leading them.

These questions were implemented to support individuals who find abstract concepts difficult to comprehend and require questions to be more concrete in nature to provide a response (Nind, 2008). Pictures represented on cards were used to support service users' understanding of questions asked. The format for staff interviews remained similar. However, questions retained more of an open focus. Both service user and staff interview schedules can be found in Appendices N and O.

2.15 Sampling strategy and sample size

In line with a single case study design, the aim was not to find a representative sample with the expectation this represents a wider population, but rather an appropriate selection of a case or choice of focus (Thomas, 2011) – in this case an LDTC within a high secure setting.

As the LDTC currently remains the only one of its kind in current existence the study sampled from the entire population, rather than employing a specific sampling strategy. Consequently, issues related to generalisability are of limited importance and indeed irrelevant to the aims of the research. The main component of understanding TCs lies within interactions between residents and staff members (Haigh, 2013). Consequently, both full time staff members and service users were invited to engage in the research in order to gain an understanding of principles in action within the LDTC according to those who spend the most time in this setting. At the time, 12 service users and 40 staff members were in residence at the LDTC within the high secure hospital. Two service users decided to discontinue treatment in the LDTC and were no longer residing in the LDTC at the time the research was completed.

Unfortunately, it was not possible to include these individuals in the research as they had since been transferred outside of the hospital at the time the research took place.

As noted above, the main aim of this study was to gain an in depth understanding of principles inherent in a unique LDTC, as opposed to generalising results to a wider population. Consequently, it was not appropriate to consider concepts such as data saturation (the point at which additional data results in little or no changes in themes (Guest, Bunce & Johnson, 2006). However, as the research focused on the single high secure LDTC in existence, this therefore increased the applicability of results via a representative sample size for the collection of themes, as the study sampled from the entire (full time) population.

2.16 Inclusion and Exclusion criteria

In order for service users to be able to participate in the study, the inclusion criteria for participation were: in receipt of treatment within the LDTC, having dual diagnoses of both learning disability and personality disorder (a given service prerequisite for admission and treatment). In addition, the service is provided for adults and is gender specific. Therefore all service user participants were adult males (age range 18 - 65 years). Individuals were also required harbour the mental capacity to provide informed consent to engage in the research and have personal motivation for doing so. All service users needed to be able to communicate and understand verbal/written English to facilitate full engagement in the interview process. Those who did not meet the inclusion criteria above were excluded from the research. However, everyone who volunteered to participate met the above inclusion criteria.

The inclusion criteria for staff member participation were: employment within the LDTC for a minimum of three years. Similarly, all staff members were required to be able to communicate and understand verbal/written English to facilitate full engagement in the interview process. Those who did not meet the inclusion criteria above were excluded from the research, although everyone who volunteered to participate met inclusion criteria.

2.17 Recruitment

Ideally, within the research, equal numbers of service users and staff members within the LDTC would have been interviewed within this study. However, service users were initially invited to partake in the research first. This was due to the particular under-representation of service users' experience in existing TC theory. Consent was requested to approach each individual service user from their designated Responsible Clinician. Subsequently, the community (staff and service users) were asked to consider approval for the research within a community meeting. Pending approval, the researcher attended community meetings to build alliances with individuals and discuss the overall study.

For service users, the initial approach was from a member of the patient's usual care team who supported them to read the information sheet and thereafter the researcher, if an interest in participation was expressed. The researcher and the member of the participant's usual care team (for service user participants) informed the participant of all aspects pertaining to participation in the study via 1:1 meetings.

Subsequent to service user recruitment, ward-based staff members and clinicians were approached to participate in the study while on shift or via their work email. While every effort was made to invite all staff members, unfortunately, ten staff members could not be approached due to remaining on permanent night shifts.

Further, the main psychologist feeding in to the LDTC had left the LDTC prior to the research commencing. Individuals who indicated an interest in participating were provided with a copy of the information sheet and offered 1:1 meetings to allow opportunity for information gathering, administration of screening questions and discussion of consent. Overall, seven staff members were eligible to partake in the study.

While six individuals agreed to participate, one did not, for reasons they did not wish to disclose. The six participants who provided consent were identified as having the greatest length of employment in the LDTC and harboured a thorough understanding of TCs.

2.18 Data collection

Participant interviews were arranged at a convenient time for both parties. Due to the nature of the client population, all interviews with service users were held on the LDTC at the High Secure Hospital. Service users were given the choice whether they would like to have a staff member attend the interview with them. Staff interviews were held within the high secure hospital in the most convenient location for the participant.

Prior to the research activity, participants were given the chance to ask further questions and written informed consent was then sought for the research. If they were willing to consent, individuals were asked to sign a consent form (see Appendix J and K). Additionally, staff completed a demographic information questionnaire requesting information on gender, age, years worked on the LDTC and training undertaken. To ease the administration burden, permission was requested from service users to access the following filed information; age, forensic history, duration of residence in TC and high secure hospital, diagnoses, and IQ. This aided contextualisation of findings.

The interview then took place, following a semi-structured format. All interviews were audio recorded. After the interview had been completed, participants were offered the opportunity to ask any questions or express any concerns harboured.

2.19 Participants – Additional demographic information

Staff

Staff training undertaken included introductory TC training during initial opening, peer review training (provided by community of communities), and training on facilitating TC group work.

Service users

Service users' index offences included; burglary, robbery, rape, indecent assault against children, wounding with intent to cause GBH. Service users' diagnoses included; mixed dissocial and emotionally unstable personality disorder, narcissistic, schizoid and histrionic personality disorders, psychopathy, psychosis, posttraumatic stress disorder (PTSD) and autism spectrum disorder (ASD).

2.20 Analysis

An Administrator employed by the high secure hospital who retained pre-existing access to clinical data transcribed the interviews. Data was transcribed at a semantic level, including words spoken and false starts. All identifying details were removed during the transcription process and participants were allocated a pseudonym. Transcriptions were checked against recordings by the researcher.

2.20.1 *Apriori decisions made for Thematic Analysis*

In line with Braun and Clarke's (2006) guidance for conducting Thematic Analysis, a priori decisions regarding coding of the data are described below. Rich description of the whole data set highlights predominant themes and is a particularly useful method for research in an area where the participants' views are unknown (Braun & Clarke, 2006).

Rather than undertaking a detailed analysis of one aspect, the decision to analyse the entire data set was taken. Braun and Clarke (2006) also suggest coding should be done at either the semantic and explicit level or the latent and interpretive level. The current study coded data at a semantic level. Both of the above decisions were made on the basis of the research aims – to represent TC members' views on whether additional important principles exist within the environment of the LDTC.

2.20.2 Process of analysis

Deductive content analysis

Initially, the data was then analysed, using a deductive approach to content analysis as described by Mayring (2000). This involved five stages. Initially, step one (category formation) and two (development of coding agenda) were completed. Main categories were formed on the basis of Haigh's (2013) theory on TC principles. Subsequent to this, definitions based on existing theory were formulated for each category, in addition to specific coding rules for each deductive category and examples to determine under what circumstances a passage of text may be coded with a category (see Appendix T for initial coding agenda).

In line with step three (revision of categories and coding agenda), deductive categories and the coding agenda were discussed and revised with supervisors. In addition, the reliability of the coding agenda was tested. Initially, a meaning unit of analysis was selected to aid identification of inter-rater reliability.

The chosen meaning unit comprised of a set of statements belonging to the same idea, located in interview transcripts obtained from staff and service user participants. It was felt this operationalisation would have the best chance of capturing TC principles, should they be evident in the LDTC environment as they are inherently nonverbal processes that can prove difficult to articulate with concise language.

The reliability of the meaning unit was tested via the researcher and research supervisor coding one service user and one staff member transcript and any discrepancies in coding were discussed. The researcher and research supervisor then segmented each transcript into meaning units and applied the coding agenda after which ratings were compared. The overall kappa coefficients for staff and service user transcripts are presented in the journal paper. The kappa coefficients for each individual category are presented below.

Service user transcript categories: attachment; 0.78, containment; 0.79, communication; 0.89, involvement and inclusion; 0.78, agency; 0.93, other; 0.89, inductive (data for inductive analysis); 0.93. All kappa coefficients demonstrated 'substantial' (0.61-0.80) or 'near perfect' (0.81-0.99) agreement (Viera & Garrett, 2005). Staff member transcript categories: attachment; 0.93, containment; 0.93, communication; 0.93, involvement and inclusion, 0.93, agency; 0.92, other; 0.92, inductive; 0.92. All kappa coefficients demonstrated 'near perfect' (0.81-0.99) agreement (Viera & Garrett, 2005).

After establishing inter-rater reliability in staff and service user transcripts, in accordance with step four (working through the text), the coding agenda was utilised to analyse results from both staff and service user transcripts. Multiple categories were assigned to meaning units versus a singular category, as, noted by Haigh (2013) TC principles are considered to overlap in a number of ways and are not mutually exclusive from each other. Staff and service user transcripts were analysed together in line with the theoretical premise that TC principles apply equally to all individuals who inhabit a given TC (Haigh, 2013).

An Excel spread sheet was used, in which each category was placed in a separate row at the left hand side. Every time a passage of text was coded with a category, the extract was copied into the spread-sheet. Each column represented an individual participant enabling the researcher to check each cell for consistency with the identified category and any differences between staff and service user accounts. Finally, in line with step five (interpretation of results), extracts were chosen that demonstrated deductive categories.

2.20.3 Thematic Analysis

An inductive thematic analysis was performed on remaining data, following the steps outlined by Braun & Clarke (2006). As above, staff and service user transcripts were analysed together. Each transcript was subjected to step one (familiarisation with the data) and two (development of initial codes). The transcript was read a number of times in order to become familiar with the data. During this process, significant and interesting aspects of the data relevant to the second research aim were highlighted and subsequently coded (see Appendix P for a coding example). The same process was replicated for all staff and service users' transcripts.

In accordance with step three (searching for themes), codes from each transcript were recorded on a piece of paper. Connections between codes were explored and possible themes identified (see section on 'saliency analysis' below for details on selection of important themes).

In line with step four, the initial list of themes were then reviewed. This involved checking initial themes against transcripts and entering these into two Excel spread sheets - one for service users and one for staff members. Each theme was placed in a separate row in the left hand column. Extracts from all transcripts related to identified themes were copied into the spread sheet. Each column represented an individual participant enabling the researcher to check each cell for consistency with the identified theme.

Subsequently, the spreadsheet was reorganised and potential themes clustered into superordinate and subordinate themes. Reorganisation involved expansion and merging of some possible themes. For example 'knowing your patient', 'giving people time and space' and 'making allowances' were subsumed under the main theme of 'responsivity'. The transcripts were referred to throughout the process to ensure themes were grounded in original data. Themes identified were also discussed with research supervisors and further refined (see Appendix Q for an overview of how themes were reviewed).

Step five (definition and labelling of themes) and six (production of report) were undertaken simultaneously. Within the final version of staff and service user Excel spread sheets, themes were arranged into a clear narrative, which was also discussed and revised with supervisors. Extracts were then chosen to illustrate themes. Themes that were identified from both service user and staff groups were compared and contrasted, resulting in identification of themes common across both groups and themes that remained specific to staff and/or service user groups. While themes specific to each group were reported separately, themes shared across the two groups were reported together.

2.20.4 Saliency analysis

As previously highlighted in the journal paper, the initial codes were subjected to a saliency analysis. Saliency analysis assigns each code one of four categories:

1. Highly important and recurrent
2. Highly important but not recurrent
3. Not highly important but recurrent
4. Not highly important and not recurrent (Buetow, 2010)

Saliency analysis was utilised as it facilitates identification and consideration of important themes from qualitative data, aiming to achieve the end result of clear and salient conclusions (Buetow, 2010).

Codes were considered highly important if participants stated importance in the text or if the code was in line with the research questions posed by the study. Frequency of code occurrence was determined by number of different participant responses that contained the code, versus the total number of times it appeared in the text. This decision was informed by assumption that the number of different individuals expressing the same idea provides a more accurate indication of importance than total number of times the idea appears overall (Namey, Guest, Thairu & Johnson, 2008).

For example, when considering the theme 'staff fit with LDTC', while a limited number of staff (3/6) commented on the subject area, when 'staff fit' was mentioned this was considered highly important to the functioning of the LDTC. The code was also in line with the research aims of the study – identifying important elements of the social climate of the LDTC that are not captured by current TC theory. Consequently, the theme was placed within the 'highly important but not recurrent' category versus the 'highly important and recurrent' category.

2.21 Qualitative results

Twelve participants were recruited for the research. The demographic details of the sample are presented in the above journal article (see 'participants' section). The duration of interviews varied between 59 and 103 minutes. Initial deductive content analysis of the transcripts identified all five categories. The categories were described in depth in the above journal article and illustrated with excerpts from transcripts. Consequently, a lengthy discussion of these will not be repeated here. However, further detail is provided on TC principles and experiences that would confirm the features within each category. In addition, further excerpts are explored below that exemplify how TC principles, specifically containment, communication and agency, may be adapted within the high secure LDTC.

TC principles of attachment and involvement and inclusion are not discussed, as there was no evidence in staff or service user transcripts to suggest these principles were adapted within the LDTC environment. Further example excerpts selected during step five of the deductive content analysis that could not be included in the journal article due to word count imposed, are provided in Appendix S).

2.21.1 TC principles and features

Attachment

The environmental culture in which attachment needs are met is described as one where community members achieve a sense of belonging and feel valued by other TC members. Experiences evidencing such a culture is apparent would be suggested by responses representing a clear sense of belonging to the TC and feeling valued by those residing within it.

Containment

This concept refers to two main elements inherent in a therapeutic environment; community members have opportunity and space to express intense emotions and have these validated and accepted by other members; community members are aware of the boundaries of what is and is not permitted in the community. Responses indicating containment infer experience of valued support offered by community members during times of distress, opportunity and space to display and experience intense emotions without immediate staff intervention, and awareness of the limits of what behaviour will be tolerated by the community.

Communication

The concept of communication involves promotion of a culture of openness where interactions are more honest, open and profound than happens in everyday situations. Responses highlighting the concept of communication indicate individuals feel safe the community will accept and digest what they have to say and/or regular opportunities are available for enquiry, commentary and questioning of others (staff and patients' actions).

Involvement and inclusion

This concept states everything that occurs in the environment is part of therapy and creates material to be discussed by community members. Examples of involvement and inclusion refer to peer pressure, rules and procedures (e.g. community meetings) and/or staff intervention to promote participation in the surrounding environment.

Agency

The therapeutic environment is said to promote agency via emphasising a network of relationships over social hierarchy. Responsibility is shared between patients and staff in specified limits and authority is fluid and questionable (Haigh, 2013). Examples of agency can include instances where responsibility is shared (e.g. voting), members taking responsibility for each other (e.g. telling others when they have broken a rule), or where community members are empowered to take whatever action is required (e.g. staff give decisions back to the community to make – “it’s your community, it’s up to you”).

2.21.2 Are TC principles modified in their application to the high secure LDTC?

Containment

A number of staff (3/6) commented on how they felt like service users' behaviour was 'not controlled as much':

[...] I like the fact that their behaviour's not controlled as much, you know, you kind of sit there, you do as you're told [in other wards], they're still displaying their behaviour.

[...] Well like I said to you when I first came on if a patient starts shouting and banging your first reaction it to get up or if two patients are arguing you're instinct will tell you to go up, get in between them and push them apart, whereas on here you might be a lot more, well you are, now lads just calm and discuss it properly.

This was echoed by a number of service users (3/6). For example, one service user stated:

[...] They want us to be able to control it [emotions and behaviour] for ourselves rather than them do it for us. That I prefer it but obviously if we do get too far out of hand and we won't control it then they will obviously step in because they have to so no one gets hurt but obviously it's us that are controlling ourselves, which is more helpful for when you move on.

Even so, other excerpts suggest a level of control is evident, and that 'discipline' is very much imposed by staff on to service users. For example, one staff member likens care provided by staff to that of a 'lion':

[...] Something that keeps going, never gives in, sensitive, caring, I keep on thinking lion...I'm trying to think of something that's nurturing that's strong, maybe yeah maybe a lion but I don't mean in an aggressive sort of way but...caring, they're very good they're nurturing animals, they teach their animals discipline and they look after them and they protect their own.

Interestingly, a number of service users (4/6) described discipline in the form of rules and consequences imposed by the LDTC as an important and 'helpful' part of the community, rather than punitive. For example:

[...] Definitely I think the rules are there it's not to punish you or something it's for your safety and the safety of others including staff.

[...] Well I don't really like rules, but personally they are a good thing really because they give you some guidelines to know what you can and can't do so it is quite helpful really.

Similarly, experiences of support in the LDTC also appear occur between service user to service user or staff to service user, rather than service users' providing support to staff. For example, all staff members (6/6) focused on containment specifically for service users:

[...] Well we're just all there together and when you're looking at things like supporting one another, the patients take as much responsibility for that as we do, you might have a patient that needs extra support and instead of automatically coming to a member of staff they might go to a peer.

[...] Yeah there's a lot of support available, they can ask for support from a specific peer they get on well with, they can ask for support from a member of staff, they can have a special meeting with either the whole of the TC if they'd like that or they can have a special meeting with the peers that are just in their small therapy group if it's something related to something that's come out in the therapy group if they're not comfortable yet talking to the whole community they have the opportunity of just talking to those that support them any way.

Parallel to staff member perspectives, service users (4/6) specifically discussed receiving support from staff versus experiences of providing support to staff. For example, one service user stated:

[...] Staff are more caring and supporting you because they're around when a patient needs support.

[...] When they're upset you either go and ask the staff to speak to them or you would basically go up to a patient and ask them for a chat if you need to speak to someone about it and you don't want to speak to a staff member at the time but then if they can't help you they'll normally let you know what staff can help you and obviously let you go to that staff or go to that staff for you, with you and do it that way so yeah.

Communication

In terms of a culture of openness, service users (4/6) reported opening up to other service users, and sometimes staff:

[...] We normally talk to each other and obviously staff if we're struggling. Figure out what we can do next if we're struggling...what is a good idea and what isn't, that sort of thing.

[...] We don't keep stuff that's on our minds, we tell staff and patients.

This was supported by staff members (5/6):

[...] I think the lads, like I say the lads in particular have become more friendly with each other rather than having their differences and getting involved in scuffles and things like that, they talk it through with each other now.

[...] It really does work because...they talk to us, they talk to the other patients.

While service users confide in staff, a number of staff members (4/6) described how they would discuss 'personal issues' with the staff team rather than service users:

[...] Obviously if we as staff have got a problem, let's say, I don't know, someone's got a personal issue, we will talk to other staff obviously we don't say anything to the patients, which you wouldn't do anyway but if we're sort on the ward and we see something on the ward that we don't like, we will say I think there's something going off between that patient and that patient and we will discuss it with the staff team or we'll take it to the ward manager or whatever, say look this isn't right what do you suggest, so yeah you can approach other staff yeah definitely.

Even so, one staff member went on to describe how they show their disagreements between each other in community meetings in front of patients, something that 'would never happen on another ward':

[...] When we're in a community meeting we might still have different views so we might be challenging a patient on something and one member of staff might think one thing and I might think another so we can potentially still clash and we could potentially, not clash, that's the wrong word, disagree, but then we're still kind of disagreeing in front of patients which would never happen on another ward, you know, you would never show patients that you're disagreeing because security would tell you that's showing that there's a split in the team and you would become maybe a target or something like that.

While differences of opinion are shown between staff in community meetings, two staff members discussed how more personal issues with staff, such as feeling 'belittled' are handled in staff process meetings:

[...] No, no, I think the staff get perfect opportunity in community meetings, you know, if there's been a particular issue with a patient, yeah it will come up on the agenda, you can get everything off your chest there quite easily, yeah and then like I said if it's an issue with a member of staff then in the process meeting afterwards so we can speak our mind there, yeah really good.

[...] You don't go home stressed and thinking I wish that staff wise hadn't of said that or done that because we have plenty of process meetings and things where we can say what we feel and I do think that's really helpful because generally speaking the old way of working was you'd probably put up with a lot and then you'd go out and have a drink after work or once a month and then you'd probably get everything out then...but we get ample opportunity, you know, two, three times a week to say what we're feeling, say if somebody's annoying you staff wise or you've felt that they've maybe belittled you, you know, anything.

One staff member went on to liken this to the boundaries of a 'parent' and 'child' relationship:

[...] We have to deal with difficult situations, I've been involved in violent situations with most of the patients on the ward throughout the years that I've been here unfortunately but that's the reality it doesn't mean to say I haven't got a bad relationship with patients, likewise as a parent has to challenge their children, discipline their children doesn't mean to say that that can damage the relationship it actually can be quite positive. You've worked through some difficult situations with that patient.

Agency

A number of service users mentioned how LDTC rules are 'more strict' than the rules on other wards (4/6). For example, one service user described how trust is specifically placed in TC members not to break the rules, and compares this as being similar to trust placed in individuals in the community:

[...] TC rules are more strict, one of the TC rules are about you taking responsibility to stick to those rules, it's like say other wards you'll probably find it hard to stick to those rules, you feel that what's the point of sticking to those rules you do what you want and then you pay the consequence. But on here on the TC, it's about you taking responsibility and you being trusted to stick to those ward rules and not break them. It's like out there if you got pulled over by the police they only pull you in if you're breaking the law, if you're not breaking the law they'll not pull you over, it's only when you do break the law or you do something the police have to get involved.

[...] They [the rules] do help you learn and help you move on quicker. It makes you stop and think.

In contrast, one service user goes on to say while the LDTC is 'supposed to be run by patients' staff intervene when needed:

[...] The ward's run by, well it's supposed to be run by the patients even though staff are on the ward watching what we're doing, keeping an eye on everything the lot so it's like the ward itself is run by patients but it just needs one person to step out of line before staff jump in and take control, not take control but try and sort that matter out there and then and say carry on, have a chat with them.

In line with this remark, a number of service users (3/6) go on to describe how staff can 'overrule' service users' decisions. For example, one service user reported:

[...] I mean if we want a ward rule changed and that we'll discuss it first, we all want to change it, we can put our hand up, yeah we want to change that but then it will go to the staff, if they don't want it changed they overrule us and say no, that's how they do it.

[...] All decisions go through patients first and then if staff agree on them and that because staff have the final, well the ward manager I should say has the last say in the rule but staff can vote with us and that say if you're on levels and all patients voted me off, then it would be down to staff because staff have the last talk about it.

In contrast, a number of staff suggested while they may 'tweak' rules, this is discussed with services users, who always have the 'final say':

[...] The patients will vote and if the majority say yes we want that rule, we will then talk about it, process meetings afterwards and we'll say yeah that's a good idea, let's put that in place or we will say well actually that's not quite right, we'll tweak it a little bit and we'll put it to them and see what they say, nothing's ever just done, it's always agreed, it's always discussed, it's never you're doing it and that's it, it's always discussed between staff and patients, but the patients basically have the final word in terms of what they want basically, it works and it always has done really.

[...] There's no sort of I'm in charge of you and I'm going to do this, there's no sort of head person if you like.

[...] Generally it's down to the patients...they will make the rules, they will bring it to the community and they'll all have a vote on it and say right yeah we like that rule or no we don't, they will pretty much have the bottom say of what rules they want and what they want to happen on the ward. Again afterwards we as staff will say right this rule's been brought to our attention, if it's okay fine and then we'll say that looks fine or if it wants a little bit of tinkering...then we will say right yeah we agree with that rule but you need to do it that way and then they'll take it back to the community and say right we can have that but it needs to be done this way so all the patients will know but yeah they will make the rule pretty much bottom line.

Another service user goes on to highlight how the rules of the high secure hospital are required to be incorporated with the LDTC rules:

[...] On here they are actually quite good because every one has been made by patients apart from the normal security rules anyway which are a part of a high secure hospital.

One service user gave an example of the general rules of the high secure hospital, involving restrictions on decisions about their care and access to kitchen materials:

[...] The only thing we don't make decisions on is your treatment pathway, your hospital appointments and all that side, your care side, but if it's to do with the rules, supporting patients, the groups we run the groups and that otherwise we do it all and the only other thing we don't do it serve meals. No but we are encouraged to help people with the menus when they can't read and write properly or they can't understand it we're all encouraged to help them and sit with them and sort it out with them instead of them going to a member of staff, we do all that side of it.

Despite additional rules imposed by the hospital, a number of service users (4/6) felt they had the opportunity to 'have a say' and have a sense of responsibility in their community. For example:

[...] It's a bit of both it's peers and staff, we'll make the decisions together basically rather than the staff do it for us and we have no say in it, we also have a say in it at the same time.

[...] I have my say.

[...] More responsibility, they give you all the responsibility you need and it's up to you what you do with it, that's why I like being on [TC ward name].

Interestingly, from one service user goes on to say, from his point of view, service users can appear stricter than staff when setting rules:

[...] The rest [of the rules] have all been done by patients on this ward, with the help of staff. Obviously with all the patients doing the rules is better but us patients seem to be a lot more strict than what the staff are to be honest.

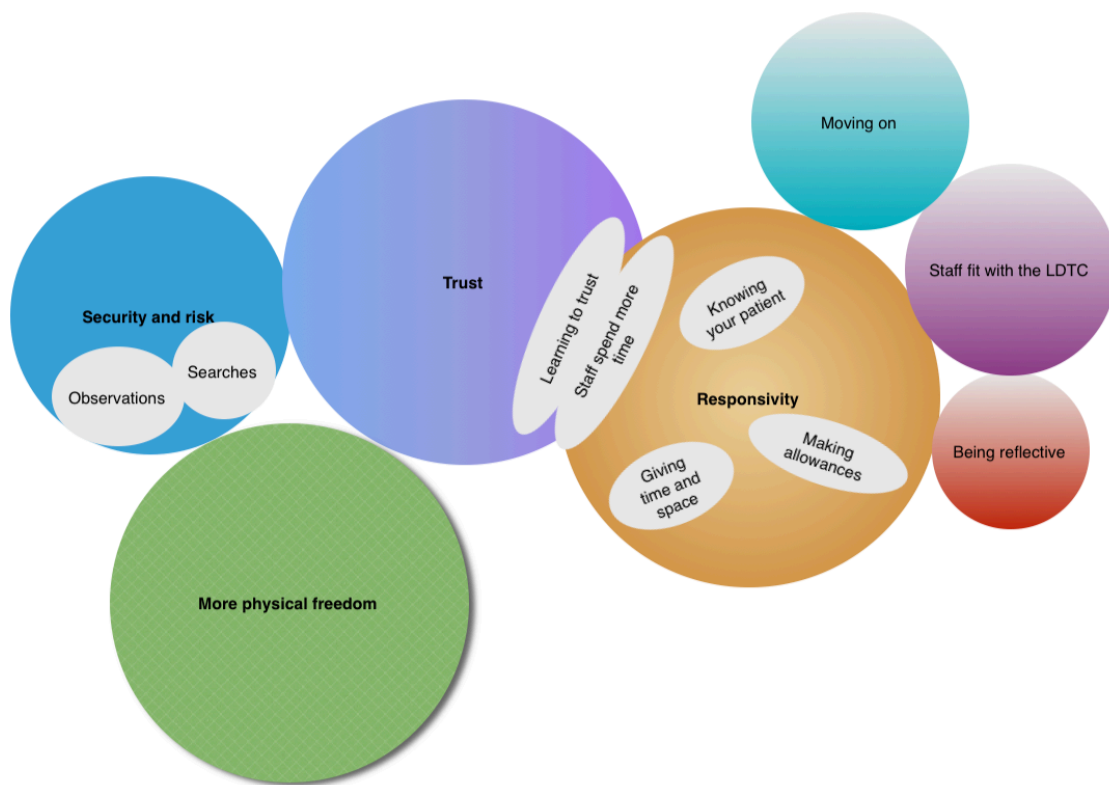
This has been picked up on within the staff team. For example, one individual states how service users are 'keener' than staff that rules are adhered to:

[...] Patients are as keen, if not keener that those rules are stuck to, patients do maintain them and then remind staff at times that Joe Bloggs has broken a rule so therefore, A, B, C needs to happen. Yeah from one angle you could see that as instead of staff controlling situations or controlling patients, controlling the environment, it's the community maintaining that safety and control.

2.22 Extended findings for thematic analysis

As noted in the journal paper, the inductive thematic analysis identified four themes. Consequently, a discussion of these will not be repeated here. The following section describes further remaining themes related to additional TC principles that were highlighted as important but not recurrent, which could not be included in the journal article (moving on, staff fit with the LDTC, and being reflective). The results presented are with reference to the expanded thematic map (see figure 3: expanded thematic map), which includes the three additional themes.

Figure 3: Expanded thematic map



2.22.1 Staff fit with the LDTC

The importance of staff fit with the LDTC was discussed solely by staff members (3). Specifically, two staff members describe how the team were specifically chosen to work on the LDTC due to their 'qualities' of nursing:

[...] We weren't particularly asked if we wanted to go onto a TC ward but the managers, ward managers, they know their staff pretty well, they know their strengths and areas that maybe, they know the qualities of the staff and personalities of the staff so they picked a bunch of staff that they thought would work well on TCs and to be honest I think they picked pretty well.

The second staff member goes on to offer more information on the 'qualities' staff members were chosen for – being 'open' and 'willing to try' a new way of working:

[...] It was felt that they would fit onto here because of their style of nursing, although at the time it wasn't really known what a TC was by perhaps people making that decision, however as it turned out that group of staff at the time were very open to try this, were willing to try this, they weren't sure what it was, what it was all about but were willing to try it.

When asked to describe the LDTC to a song, a staff member goes on to emphasise the importance of the staff members' ability to 'roll with it' together as a team:

[...] Roll with It, Oasis, what about that one? Umm because that's what we do I suppose, you know, we've got the treatment model and all the policies and procedures but every day you come in, every day's different, could be a good day, could be a not so good day but we just have to come in and we just have to roll with it, you go in the group, especially the Wednesdays groups, that's just about rolling with it, coming in, they could have something they're really struggling with that they want to talk about or could be something positive that day you just don't know. whatever it is you're never on your own, whatever it is we've got to roll with, we do it as a team and the support's always there and draw on us experience I suppose if something like that has maybe happened before or if it hasn't then we just find us way as best we can.

Again, 'staff fit with the LDTC' also appears linked to the theme 'Responsivity' as particular staff qualities are described to positively influence staff's ability to respond to what is happening in the here and now on the LDTC.

2.22.2 Moving on

The theme 'moving on' was highlighted by a third of staff members (2/6) and one service user, who stated:

[...] It's because I'm moving on, we're getting new faces coming on near enough all the time now and all like that and it's not like the old people who have been on here from day one because we've still got quite a few of them still on here and you're getting all these new ones coming on and you're getting new staff now and again, it doesn't make me feel like the community's working for me anymore, it feels like it's getting dragged away from me, that's why I don't like it no more.

Staff members seemed to pick up on difficulties service users face with moving on and have attempted to respond to this by introducing a group to support them with transitioning to a new service. For example, one staff member commented:

[...] We're looking at doing a six-week group on moving on because of the difficulties associated with moving on. It's not a bad environment for them to be on and the support mechanisms they understand the environment, how things work and whatever then it's all exciting moving on but the reality is they don't know the environment, they don't know the staff, they don't know the other patients, what's expected of them and there's more restrictions maybe on them, at least initially. It can be a scary thing and people get bothered and things can go wrong because they want to come back some of them and they can't cope so we're looking at doing a moving on group potentially, so that's the sort of thing we have on a Tuesday.

Indeed there appears to be a practical rehabilitative focus on preparing people with the necessary skills to 'move on' and adapt to community living. For example, one staff member talks about educating individuals on communication and social skills:

[...] Yeah a bit more flexibility, so they have got the potential to get rowdy but I suppose once they do get up there we do try and bring them back down a bit and try and kind of remind them where they actually are still and that certain language isn't appropriate in any setting and we try and say to them like we did the other day, for example if you was on a bus that language isn't acceptable, if you was in a shop that language isn't acceptable. We're trying to set you up for when you move on and we're telling you that it's not acceptable or somebody might challenge you on that and if you've got issues with your anger and somebody's telling you how to talk you might flair up all because you're swearing and anybody's got a right to ask you to watch your language.

Overall, surrounding staff demonstrate an awareness that the experiences and needs of service users who were nearing the end of their journey on the LDTC differ from those who had spent less time on the LDTC. The theme of 'moving on' is therefore clearly linked with 'staff fit with the LDTC' and the main theme of 'Responsivity' – staff's ability to comprehend and respond the current situation in front of them.

2.22.3 Being reflective

Following on from qualities resulting in 'staff fit with the LDTC', one staff member highlighted the importance of 'being reflective' as a team when considering situations that unfold on the LDTC and felt this was enhanced by having a Psychologist employed permanently on the ward:

[...] Umm, with other, the relations with the staff there's a much more reflective process goes on between, you know, amongst staff daily, you know, whether that just be informally in the office or the process meetings, you know, it's much more reflective on our practice on what could be happening in a certain situation and everything like that, which I think helps to build stronger working relationships between us and our understanding's been brought on as well by it being a multi-disciplinary thing the TC, more often than not we've had Psychologists permanently with us, that's not been the case for the last few weeks but I'm sure that's being sorted, so they've helped bring our understanding on certain things as well and certain things that the patients present with.

Being reflective links both with 'staff fit with the LDTC' and the main theme of 'Responsivity' as engaging in reflective thinking informs the responsive action staff members take in day to day situations on the LDTC.

2.23 Ensuring quality and trustworthiness

2.23.1 Quality and transferability of the research

In evaluating quality and trustworthiness of qualitative research, four principles, suggested by Guba (1981) are often used to guide the review process. These principles include; credibility (how congruent are the study findings with reality?), confirmability (can the findings be confirmed by others or influenced by the researcher's bias?), transferability (how transferable and applicable are the results to other settings?) and finally dependability (is the analysis consistent and replicable?). Guba (1981) has provided a number of strategies to enable researchers to retain the above qualities in their research, which continue to be advocated (Shenton, 2004). A number of these strategies were utilised below.

To increase the credibility of the analysis and results, Guba & Lincoln (1994) suggest prolonged engagement with the organisation whom research is conducted with to build relationships and develop understanding as to the context of the research. Consequently, the researcher made a number of visits to the high secure establishment to both gain an understanding of the organisation and build a relationship of trust between both parties. Each individual invited to partake in the research were provided the opportunity to decline to ensure participants only included people who genuinely wished to take part and provide information.

The independent status of the researcher from the organisation was also emphasised to ensure participants felt able to discuss experiences without fear of losing credibility in the eyes of managers or the overall organisation. In addition, during interviews, iterative questions were used where the researcher often returned to matters previously raised by a participant to extract related data through rephrased questions. For example, when a participant presented conflicting pieces of information, this style of questioning was used to detect discrepancies and explore participants' perspective of a given area.

This strategy was particularly useful given the often high level of suggestibility with individuals who have a learning disability (Gudjonsson & Henry, 2011). Finally, the qualitative analysis and results were subject to peer scrutiny by both colleagues and research supervisors which both facilitated refinement of the deductive coding framework and of main categories and themes in the content and thematic analysis.

Due to the unique nature of the population under study, a limited focus was placed on the principle of transferability within the research. As the high secure male learning disability therapeutic community remains the only population currently in existence, the aim of the research was to generate an in depth understanding of TC principles inherent in the LDTC versus generalising results to a wider population. However, as the research focused on a niche population, the applicability of results was increased due to the study sampling from the entire population.

Transferability was also explored via discussions with supervisors, which supported clarification of different categories, themes and links between them, leading to a re-organisation of deductive categories and the overall thematic structure.

Dependability was supported by detailing the process of analysis, audio recording interviews, and transcribing them verbatim. An audit trail was also maintained, including the transcripts, records of themes at each stage of analysis and maintaining a research diary (Guba, 1981). Completing a research diary enabled the researcher to track the development of ideas in order to prevent any held preconceptions of the subject preventing new insights ultimately leading to bias in the analysis (Coar & Sim, 2006; see Appendix W). Detailed quotes were also used in the analysis so as to preserve context within the analysis and allow future comparisons with other settings (Guba, 1981; Shenton, 2004).

Finally, confirmability was ensured via regular use of supervision to test and develop analysis and subsequent interpretations made by the researcher. Furthermore, the guidelines for thematic analysis (Braun & Clarke, 2006), and deductive content analysis (Mayring, 2000) were followed and pictorial examples of each step of analysis were used to both heighten quality and ensure transparency of the analytic process. Finally, to improve reliability of ratings, inter-rater reliability checks were conducted on both staff and service user transcripts via calculation of kappa coefficients for each deductive coding category (all meeting levels for 'substantial agreement' or above; Viera & Garrett, 2005).

3. Extended Discussion

3.1 Overview

The research set out to explore whether Haigh's (2013) quintessence principles were experienced by TC members within the LDTC environment and identify whether any additional principles were in existence that remained unaccounted for by existing theory. This was an area that had not been researched previously and was timely in its completion in light of recent calls within TC literature to provide empirical verification of Haigh's (2013) quintessence principles. To explore Haigh's (2013) therapeutic principles within the LDTC environment, a qualitative design was used to investigate staff and service users' experiences of Haigh's (2013) principles with a smaller group.

This section expands on the discussion presented in the journal paper, with a specific focus on adaptations evident to TC principles in the LDTC and further consideration of important but not recurrent themes identified within the saliency analysis in the context of existing research. The unique contribution made by this qualitative investigation to the literature is also discussed. Finally, the section goes on to highlight the strengths and limitations of the study in addition to recommendations for future research. Finally, the research is reflected on, involving a critical consideration of theoretical, scientific and ethical issues raised by the research.

3.2 Summary of key findings

The findings of this research can be separated into three main areas: impact of the high secure environment on TC principles, the LDTC and its differences from other ward environments, a staff team's 'fit' with the LDTC and TC principles and their relationship with patient-centred care.

3.2.1 Is the nature of the high secure environment trumping TC principles?

The answer to this question appears to be both yes and no. Based on the results, while there is evidence of containment, communication and agency within the community, there may be slight adaptations to the use of these TC principles. The principles are considered in turn below.

Containment and communication

In regards to containment, the general theme across excerpts demonstrated how staff support service users or service users support each other in expressing and containing their emotions. There were no reported experiences of staff receiving emotional containment from service users. This would make sense ethically, as if staff usually require help from others in containing their emotions it would not be appropriate for them to work with individuals with complex needs in conditions of high security due to possible risks posed to themselves and others, particularly when working with people with a diagnosis of PD where there is a temptation for staff to retreat emotionally (Hinshelwood, 1999).

More generally, staff members who are unable to contain their own emotions will undoubtedly find it hard to provide a containing experience for others when experiencing emotional turmoil (Moore, 2012). As noted by Houzel (1996), therapists need to be able to work together to contain individuals' externalised conflicts (inability to integrate different parts of the inner self) in a meaningful way and through this process, the conflict is made digestible for the individual, allowing them to 'own' it back.

Applied to TCs, Edelson (1970) names this as the therapeutic environment maintaining integrity in the face of the service users' 'inner chaos'. By doing this, the community (peers and staff) provide an 'auxiliary ego' which provides external controls to service users who's inner controls have not yet developed fully or lapsed. Individuals are then able to distinguish between inner and outer reality over time, eventually allowing them to create constructive interactions with others (Nativ, 2014).

In terms of communication, it appears clear both staff and service users express what is on their minds within community meetings. Staff members also feel comfortable demonstrating their different points of view with other staff members in community meetings – something that is usually prohibited in wards in a secure hospital to prevent ‘splitting’ (projections of good and bad aspects of the self on to the staff team) in the team (Neilson, 1991). That being said, some staff members reported that they would only discuss issues of a personal nature within staff process meetings.

The above actions of staff may reflect the tension between managing security and delivering therapy - an issue reflected in other secure TC settings (Clarke, 1996; McManus, 2010). McManus (2010) goes on to highlight how the host organisation can contribute to this tension by demanding high levels of security while remaining unsupportive of staff in their role to perform more rehabilitative and therapeutic tasks. This is illustrated in some contextual data related to attitudes of those external to the LDTC. For example, one individual described responses from the wider hospital in regard to the idea that service users have the opportunity to vote on matters in the community:

[...] If I went to a meeting and I was feeding back say on issues on him here and if I was to say we've got a patient, he's going through his four week trial period at the end of that we'll have a vote, you know, within the room you might hear a few sniggers, you know, what's all that about type of thing...you'd be questioned on it, you know what's voting about and then you try and explain the voting and you'd get a disparaging comment, you know, but it's because they don't know how it runs, it's comments about the ward when they don't know how it actually runs, the philosophy of it, the workings of it, so it's an opinion they've already formed and stuck to and rumours aid that opinion to remain with them rather than know what actually goes on.

The reactions of the wider host institution have been well documented in existing literature, in terms of service integration and its impact on TCs (Cullen & Miller, 2010; Rawlings, 2005).

That being said, as the community itself appears to have applied the culture of 'openness' to its interactions with the wider hospital, relations between the LDTC and high secure hospital seem much improved. One staff member talks about how sharing of TC outcomes and openness to visits have changed wider attitudes in the hospital:

[...] As time went on I think it was mainly from outside people coming into the hospital and seeing what we were doing raised the awareness of what was happening on here as I said earlier, seclusions stats and incidents going down and complaints going down so I think there was a realisation that oh actually what is happening on there, how come they keep maintaining these stats...within the hospital attitudes from certain areas towards us changed became more positive, it was more supportive, it was more understanding because they could see it was working, they might not have been sure how the TC works and all the principles, philosophies but they knew it was working so therefore the support level grew which has enabled us to develop along the way.

The individual goes on to compare the LDTC and its level of freedom within the hospital to that of a 'dove':

[...] A dove. As though it's been set free. Free to develop and free to expand, free to try and be a TC within this environment, I'd say that support is there now which has allowed us to develop a bit more freedom in what we do as a TC so I suppose a dove.

In lieu of the above, creativity in the application of TC principles in niche and novel environments may ease integration in to the overarching service and ultimately help the TC and its features to flourish. Indeed, the rise of 'day TCs' and 'mini TCs' suggest there is room for flexibility and creativity in implementing TC principles without compromising on quality in unique and novel environments (Pearce & Haigh, 2008).

In consideration of the above two principles and the extent to which they are employed in the LDTC, a further question comes to mind –is this the way TC principles were intended to be implemented anyway - that staff facilitate a care giving role?

Interestingly, there is limited literature on the way TCs in non-secure environments apply principles of communication and containment. Literature that does exist implies these principles are employed in a similar fashion (Nativ, 2014; Vigorelli, 2014).

Haigh (2013) states the principles embedded within an environment are there to provide an emotional climate to support secondary emotional development, where achievement of primary emotional development has not been reached previously. Primary emotional development is carried out by surrounding caregiver/s. Therefore, it would seem a similar relationship would apply to those providing secondary emotional development – that of a parental relationship. The relationship between caregiver and child is undoubtedly more one sided, with the caregiver being tasked with setting boundaries, containing emotions to provide the child with a learning experience that can be internalised to form a sense of emotional safety and also enable self-soothing (Haigh, 2013).

While the caregiver can communicate with the child, enjoy mutual understanding of common problems, find meaning through this connection alongside expressing disagreement, it might be that more personal concerns would typically be shared with a partner or surrounding friends. In terms of supporting adults with their emotional development, while Haigh (2013) places emphasis on transparency of communication between staff and service users, the level to which this is taken remains ambiguous.

Consequently, the question remains of just how much should staff share with service users? Where does the boundary lie? The way the principle of communication is described by Haigh (2013) suggests there is some flexibility for the service itself to draw this boundary. Indeed, when reflecting on his quintessence principles, Haigh (2014) states, an important part of the work in TCs lies in specifying the limits and ensuring the space within them is free from authoritarian or management contamination.

Agency

In regard to agency, service users felt they had a say in what happens in their community, were able to vote on community rules to be instilled and take responsibility for each other's actions. Even so, the ways in which principles of containment and communication are applied imply limitations to the 'flattened hierarchy' feature of the principle of agency. This is further reflected in the set definitions between 'staff' and 'patient' roles explicit within staff and service user transcripts and further confirmed difficulties in implementing a flattened hierarchy within a high secure psychiatric setting. For example, one staff member stated:

[...] Ultimately the patient would be supported in whatever way as necessary at that moment to alleviate that distress...support from staff to patients is there sort of on tap as such.

By comparison, in community based TCs, individuals would usually be referred to as TC members or 'residents' (Rawlings, 1998; Stevens, 2010). Interestingly, Haigh (2013) does state, responsibility is to be shared between staff and service users 'in specified limits'. Indeed, research by Clarke (2015) suggests limits to agency were evident in two community TCs in the U.K. Clarke (2015) identified while individuals spoke of a flattened hierarchy existing, differences in power were evident between less and more experienced TC members and service users and staff.

However, differences in power were not always construed negatively (e.g. staff exercising authority to contain powerful negative emotions experienced by service users was considered helpful), and in many ways power hierarchies were fluid and open to change rather than flattened. Consequently, it is likely authority within a given TC may fluctuate depending on current circumstances, such as when a risk to the safety of others is posed.

While there may be limits to agency in all TCs, the limits imposed in the LDTC will undoubtedly be influenced by its situation within a high secure hospital, as the rules of the high secure hospital are also incorporated with the TC rules. In contrast however, one service user felt they, as a group were stricter than staff members in implementing community rules. Staff also confirmed this. It is possible, that in light of this complex population, staff intervention and limits to agency are important, not only to keep in line with the rules of the high secure hospital, but also to maintain fairness in the community and prevent punitiveness.

In sum, it is possible the LDTC is operating in the best way it can, and, despite the constraints of being located within a high secure hospital, TC principles are employed to a similar extent that they would be in a community TC setting, regardless of specified 'staff' and 'patient' roles.

3.2.2 Are there any benefits of the LDTC being located in a high secure setting?

Fundamentally, some benefits can be highlighted from the LDTC being situated within a high secure setting. For example, as service users are not able to leave the LDTC instantaneously, the community benefits from a more stable service user population which may help to facilitate TC principles, particularly the initial principle sparking secondary emotional development, namely attachment. With a more stable service user population, more time is available for the development of therapeutic attachments between service users and service users and staff members. In addition, due to security arrangements within the high secure hospital individuals tend to spend an increased amount of time on the LDTC with peers and staff members. This feature of the environment may help to increase the tangibility of the principle of involvement and inclusion, supporting service users to hold the rest of the community in mind.

3.2.3 Is this LDTC different to other ward environments?

Inpatient TCs versus general ward environments

Generally speaking, two factors have been proposed to contribute to TC effectiveness; promotion of a sense of belonging and the capacity for responsible agency (Pearce & Pickard, 2012). While both elements can be found in other therapeutic approaches and indeed general wards, it is the combination, extent and emphasis on these factors that make TCs unique. TC environments are specifically structured to promote a sense of belongingness via frequent contact with others (community meetings, formal and informal activities etc.), longitudinal stability of relationships (members are normally expected to stay for the duration of treatment – a minimum of 4-5 years on the LDTC), and the presence of mutual concern (relationships between community members are specifically characterised by challenge, support and shared responsibility). To promote agency, a TC places explicit expectations on community members to hold responsibility for their own behaviour (e.g. challenging each other to take responsibility for unhelpful behaviours, community imposed consequences for unhelpful behaviours, voting on decisions as a community).

Due to the 24/7 nature of the environment, TCs are hypothesised as uniquely placed to combine concepts of belongingness and responsible agency. As members develop a sense of belongingness to others in the community, self-esteem may increase, motivating behaviour change (Pearce & Pickard, 2012). While effecting behavioural change carries risks of members feeling a failure should they not meet standards set by themselves and the community, the strength of the sense of belongingness experienced by TC members acts as a buffer during such times. The community is characterised by positive regard and mutual concern, which not only motivates members to change due to their valuing the community but also provides protection from judgement through compassion when difficulties are experienced.

LDTC versus general ward environments

More specifically, the LDTC environment differs in a number of ways from TC inpatient community and prison settings, particularly in regard to increased complexity of service users' mental health problems and higher conditions of security (limiting physical movement/engagement in certain activities) due to increased clinical risk levels within the clinical population.

For example, the LDTC harbours a number of specific differences from prison TCs. While the demographic group comprises of people with an offending history and difficulties that would meet criteria for a diagnosis of personality disorder, requirements for meeting this diagnosis are not always specified or required (for example, HMP Dovegate – Miller & Brown, 2010). The client population within the LDTC also harbours differences to that of a typical clinical population within an inpatient community TC. While service users are likely to have mental health diagnoses, such as a personality disorder, it is unlikely individuals will have an offending history and therefore security conditions operate on a lower level. TCs in community settings are therefore better placed to offer increased physical freedom/integration in to the surrounding community.

Staff perspectives on personality disorder and learning disability within forensic services

Additionally, it is well established that staff attitudes towards individuals with a diagnosis of personality disorder are generally negative and pessimistic in regard to treatment efficacy and outcome (Bowers et al., 2006; Bowers, McFarlane, Kiyimba, Clark & Alexander, 2000; Newton-Howes, Weaver & Tyrer, 2008). Literature investigating staff perspectives within high secure hospitals has highlighted increasingly stigmatised perspectives amongst staff members in regard to this client group.

For example, after conducting a literature review of nursing care for individuals with 'severe personality disorder', Bowers et al. (2000) identified limited consensus among staff in high secure hospitals as to whether service users with such diagnoses should be placed within the healthcare system or detained in prison.

Interestingly, a core influential factor in staff attitudes included training on personality disorder and self-management methods to help staff contain their own emotional reactions toward service users. At the time of writing, no literature is currently available exploring staff attitudes toward individuals with dual diagnoses of learning disability and personality disorder within high secure services. However, given the double stigmatisation individuals have been reported to experience as both an offender and as a person with a disability within prisons and other forensic systems (Morrissey & Taylor, 2014), it is possible the experiences of service users with an additional diagnosis of personality disorder receive less than adequate treatment by staff members within high secure services.

3.2.4 Staff fit with the LDTC

An important but not recurrent theme highlighted in the saliency analysis alluded to the significance of 'staff fit' with environment. Staff members described how they were selected to work on the LDTC due to their openness and willingness to try a different way of working. In consideration of shared staff perspectives on working with service users with a diagnosis of personality disorder in high secure care (Bowers et al., 2000) and the overall focus on risk management at the expense of therapeutic relationships, the mind-set of staff on the LDTC appear to lie in contrast with the views of the overarching culture of the high secure hospital.

As noted by Taylor & Trout (2013) the Democratic Therapeutic community (DTC) model specifically focuses on the social milieu and uses the community and relationships within it as a vehicle for intervention to challenge anti-authoritarian and anti-social attitudes residing in forensic settings. Such an environment poses a direct challenge to how care is usually employed in secure settings and may therefore attract a specific kind of staff team. Indeed, Taylor, Morrissey, Trout & Bennett (2012) describe how the facility was specifically staffed by experienced learning disability forensic nurses.

Those without learning disability experience were seconded to forensic LD settings within the hospital and neighbouring NHS Trusts (Taylor, MacKenzie, Bowen & Turner, 2012). Moos (2012) has previously highlighted how more flexible and varied services valuing staff and resident involvement tend to attract better trained staff and thereby positively influence the surrounding social environmental resources e.g. improved interpersonal relationships between staff and service users/increased opportunities for personal growth, or in terms of Haigh's (2013) quintessence principles, aiding implementation of involvement and inclusion, communication and agency.

Interestingly, one staff member suggested a core skill of the staff team was their ability to care for individuals more flexibly within a novel treatment model by 'rolling with' whatever happens on the LDTC on a daily basis. The importance of flexibility in supporting individuals with personality disorder diagnoses has been highlighted in existing literature. Critchfield & Benjamin (2006) emphasise the importance of flexible boundaries – flexibly responding to genuine needs of the person while maintaining firm boundaries in critical areas. They go on to suggest potential boundary transgressions require individual consideration, taking in to account knowledge of the service user, to enable staff to respond in a humane and therapeutic way.

Drawing on experience as a team was also felt to be pertinent in employing a flexible approach. This relates to influential factors noted in the literature around the importance of staff training/knowledge of personality disorder and resulting behaviours, positively informing staff attitudes towards individuals with these diagnoses and subsequent care (Bower et al., 2000).

3.2.5 Being reflective – addressing service users' needs in moving on

Another way in which the staff team may differ from other wards is via their ability to reflect and mentalise others' perspectives. One staff member described how staff would take time inside and outside of formal meetings to reflect on interactions within the community and what these might mean.

Bateman and Fonagy (2010) term the above behaviour as 'mentalisation' – the ability to read and be aware of our own intentions as well as other people's and to be able to regulate thinking and feeling simultaneously (Adshead, 2015; Bateman & Fonagy, 2010: 11; Fonagy, 1989). Unfortunately, those with insecure attachments, such as those individuals who find themselves in TCs, tend to have a low mentalising ability due to previous caregivers remaining unable to understand and respond to their internal states during infancy.

In adulthood, individuals go on to struggle with the experience of distress and ways of responding to this, negatively impacting on relationships with others (Adshead, 2015). The mentalising capacity of the staff team and its regular use amongst staff members in the LDTC is therefore of fundamental importance as it serves to help improve service users' mentalising function and further inform the development of therapeutic relationships. Through understanding others' states of mind, staff are able to attune and empathise with individuals' emotions, providing an experience of emotional congruence and enabling provision of appropriate support (Bateman & Fonagy, 2010).

This would explain the theme of moving on, highlighted as important by staff and service users. Through being able to mentalise service users' anxieties of moving on, staff members have responded to the issue and provided necessary support in the form of a bespoke psychoeducation group.

3.2.6 What about the community impact on the staff team?

It is important to note that while staff were surveyed in relation to their preferred place of work during allocations made to the LDTC, none were guaranteed their preferred choice and all appointed individuals had no prior TC experience (Taylor & Trout, 2013). Consequently, aside from benefits provided by the staff team to the LDTC, employment within the LDTC may also have a direct and positive impact on the staff team. The community itself may offer a number of features that facilitate a supportive and cohesive staff team. For example, ample opportunities for containment for staff members are provided via process meetings for staff on a weekly basis to support them in processing their own emotional reactions towards service users. Staff members also described how staff team itself is containing for team members (e.g. 'whatever it is you're never on your own, whatever it is we've got to roll with, we do it as a team'), aside from process meetings offered.

Further, prior to working on the LDTC, staff were provided with training on the LDTC treatment model, overall goals and roles/responsibilities for staff and service users within the community. As the style of working represents a distinct departure from the rest of the high secure hospital, staff members may have increased sense of feeling part of a community in which they are consistently made to feel involved and included. Previous literature has highlighted the benefits of healthcare systems that promote involvement, staff orientation and role clarity, such as higher staff performance and staff satisfaction (Moos, 2004). Moos & Moos (1976) found that staff in a supportive and goal directed workplace were more likely to create a supportive and goal-directed treatment culture. In consideration of the above, it would appear the LDTC harbours benefits for staff within a high secure setting, in addition to service users.

3.2.7 In what way are TC principles more than patient-centred care?

An initial consideration of the definition of patient-centred care is pertinent to answering this question. Patient-centred care can be defined as the following: 'care that is holistic, empowering and that tailors support according to the individual's priorities and needs' (Royal College of General Practitioners [RCOGP], 2014). While a TC may incorporate the above characteristics, it is the extensive opportunities offered by the 24/7 nature of the treatment modality to build a sense of belongingness to a group and develop agency over one's own care that distinguishes TCs from more general ward settings (Pearce & Pickard, 2012).

Indeed, as noted by Morris (2004, p.36) in describing severe PD pathology, 'with deeply ingrained maladaptive patterns that comprise this group's personality disorder, high intensity, high dose treatment is required'. As noted above, in contrast to patient-centred care, the TC environment is purposefully structured to engender multiple opportunities for fostering therapeutic relationships and taking responsibility for oneself and others (allocation of community jobs, communal votes, regular community meetings).

Controversially, it has been posited the principles of patient-centred care have been taken from therapeutic communities and sanitized, such that the power of the group is lost (R. Haigh, personal communication, 6 June, 2015). Indeed, as noted by Pearce & Pickard (2012), it is the power of the group - the sense of community and peer support that is thought to provide a compassionate and nurturing space within which individuals can begin to practice agency safely. Within conditions of high security, Individuals with a learning disability can lack the capacity to manage or think about their feelings. Consequently, individual's needs are often communicated behaviourally by 'acting out', which may further serve to fracture relationships between staff and service users. Therefore, there is particularly strong justification for a treatment modality, such as an LDTC, that goes beyond patient-centred care by employing structures to instil a sense of community that can withstand high levels of violence and aggression.

TCs as a psychologically informed multi-modal treatment

In further contrast to principles of patient-centred care, TCs are grounded in psychological theory to facilitate a multi-modal treatment environment. Previous research has identified treatment outcomes for offenders with a personality disorder diagnosis have been enhanced when exposed to treatment that is integrative and eclectic in nature (Bartak et al., 2007; Livesley, 2003).

As reported by Shuker (2010), while work within TCs was originally described in relation to psychodynamic principles emphasising exploration of early attachment, emotional experiences and unconscious processes, over time, TCs have evolved to draw on a range of theoretical models in practice to meet complexity of individuals' needs. Consequently, thinking around theoretical processes inherent within forensic TCs has expanded to include social learning, and cognitive behavioural processes, as opposed to purely psychodynamic factors (Shuker, 2010).

Within forensic TCs, service users engage in reality testing of beliefs and assumptions about others within the TC and have these explored and challenged by TC members. Social learning also occurs through observation of peers and staff modelling prosocial behaviours supporting individuals to learn alternative ways of being (Shuker, 2010). Facilitation of numerous opportunities for individuals to generalise and apply skills acquired to daily activities outside of formal therapy sessions helps to provide a more concrete learning experience than that offered in 1:1 therapy, which is of specific value to individuals with a learning disability (Willner, 2006).

TCs and curative factors in psychotherapy

A further difference between TCs and patient-centred care is in regard to identified curative factors in psychotherapy. While it could be said that patient-centred care can involve some curative factors; the development of a therapeutic alliance (a bond, and agreement on tasks/goals), and therapist attunement of the emotional experience of the individual (Wampold, 2015), TCs can be seen to incorporate and emphasise a number of additional known common factors important in favourable treatment outcome. For example, TC members are encouraged to confront and challenge each other in regard to their behaviour in the community to promote psychological understanding of their actions. This feature of a TC environment, maps on to confrontation/facing problems, which is an empirically supported factor for therapeutic change (Weinberger & Rasco, 2007).

TCs also provide numerous opportunities for mastery/control experiences (e.g. via community votes, encouragement to make their own decisions), which will serve to influence patient attributions of successful outcome to internal/external causes (Weinberger & Rasco, 2007). For example, an individual with increased opportunities to take responsibility over their own and others behaviour may be more likely to attribute their gains in therapy to their own hard work versus the actions of others. Individuals who attribute progress to internal attributions, are less likely to relapse in future whereas those who attribute change to external causes are less likely to maintain improvements post therapy.

TCs and enabling environments

Similar to patient-centred care, TCs also go above and beyond enabling environments. A common difference pointed out between enabling environments and DTCs is the use of group/individual therapy in TCs. An additional difference lies in the absence of a requirement for a 'flattened hierarchy' within enabling environments. Instead, enabling environment principles place emphasis on the importance of leadership – individuals nominated to ensure the environment remains enabling.

While individuals are encouraged to challenge decisions and ask questions, there is no indication power structures are intentionally ‘flattened’. Within the interview transcripts for the research, a number of individuals highlighted how much they valued opportunities to be privileged with the same opportunities for decision making as staff members (e.g. ‘There’s less of a power imbalance. They give you all the responsibility you need and it’s up to you what you do with it, that’s why I like being on [TC ward name]’).

While the principle of agency is constrained to a degree (for example, members cannot make decisions in regard to matters relating to security or their care pathway), due to the high secure nature of hospital, this feature of the environment was still valued by members of the LDTC and may represent the importance of more fluid hierarchies (Clarke, 2015).

Table 3 – Differences between inpatient TC, Psychologically Informed Planned Environments (PIPEs) and general wards

Criteria	Inpatient TC	PIPEs	General wards
Curative factors	Specific focus on implementing curative factors – alliance, empathy, mastery/control, confrontation/facing problems via day to day TC practices e.g. community meetings	Some focus on implementing curative factors; particular focus for staff on relating with service users and developing the quality of these relationships but not as focused and explicit as is in a TC.	May be present (e.g. alliance, empathy) but no specific focus on engendering these in environment
Psychological	Grounded in psychological	Not formally grounded in	Not formally grounded in

theory	theory to provide multi-modal treatment for personality difficulties; psychodynamic, cognitive behavioural and social learning theory	psychological theory but staff are provided with specific training to develop psychological understanding of their work.	psychological theory
Therapy	Group/1:1 – on site	No therapy	Group/1:1 – off site
Hierarchy	Intentionally flattened – service users have opportunity to make same decisions as staff	No specific attempt to flattened hierarchy. Leader emphasised instead to make environment enabling	Hierarchy exists between staff and service users
Accreditation	Accredited by Community of Communities (C of C)– has to meet specified values and practices. Gives identity as distinct treatment entity with clear membership	Also accredited by C of C (as an enabling environment), but according to a more flexible set of values and practices. Gives identity as psychologically informed	No accreditation.

	boundary.	environment versus treatment entity.	
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3.2.8 Additional principles and patient-centred care

A number of the additional principles identified within the thematic analysis may be understood as resembling principles of patient-centred care versus novel therapeutic features or TC principles. The themes of responsiveness, moving on, staff fit with the LDTC, tie in with the perspective of adopting a flexible approach to individuals' care according to their needs and priorities and taking a holistic view of the individual. However, as the research was undertaken as a single case study design, with the LDTC representing an 'outlier' case, the generalisability of the inductive results may be limited. It is therefore possible the additional themes identified in the research are idiosyncratic to this specific LDTC and would not be observed in other TCs.

While patient-centred care principles exist in literature, these are not necessarily translated in to practice. This is evident within the definition of the principles themselves. For example, 'the need for a collaborative relationship between patients and professionals...' (RCOGP, 2014: 5). The language used acts as an oxymoron to the idea being communicated as the notion of empowerment falls flat against the unyielding power imbalance represented by the labels of 'professionals' and 'patients'.

The language utilised in patient-centred principles reflects the cultural crisis that has comprised modern healthcare, epitomised in the dissolution of Mid Stafford Trust. The TC model provides a much-needed antidote to this crisis by preventing secret-keeping and hierarchical decision making via encouraging transparency and responsibility to uphold rules and engagement in regular open communication with individuals and the wider organisation (Campling, 2015, p. 23).

With core practices within a DTC promoting patients and their peers as experts, shared decision making and reflective practice within staff teams these components provide a solid platform upon which patient-centred care can be delivered within inpatient services as an adjunct to multi-modal therapy, particularly for learning disability populations and those residing within forensic contexts (Taylor, Crowther & Bryant, 2015). Without the framework of a TC, patient-centred principles may be lost as the structures that guide their implementation are absent.

Responsivity – Is it a TC principle?

The principle of responsivity identified during the inductive analysis was considered particularly important in terms of staff and service users maintaining awareness of how others are currently feeling and adapting approaches to support based on this. One could argue responsivity is not a TC principle as it is not explicitly linked to provision of a secondary experience of emotional development (Haigh, 2013) and more about general care. Indeed, responsivity comes under the definition of patient-centred care, ‘tailor[ing] support according to individuals’ priorities and needs’ (RCOGP, 2014).

However, the notion of responsivity is particularly important in working with people who have diagnoses of personality disorder. It is commonplace for these individuals to have been deprived of experiencing care via an individual who is attuned to their needs. Add to this the prioritisation of managing security and risk within secure services over adapting care to individuals’ needs, staff often end up in advertently modelling individuals’ previous traumatic relationships where their needs have neither been considered or met by others.

Consequently, it is crucial staff are supported to develop an awareness of the importance of responsivity and model this in their relationships with service users by responding more flexibly to their needs in line with the concept of ‘spongy boundaries’ (Critchfield & Benjamin, 2006).

In so doing, responsivity can be used in forensic environments such as the LDTC, in a theory-informed way through utilising this process as a means of updating service users' internal working models on relationships as opposed to standard 'patient-centred care', often implemented as a 'tick box' exercise in the absence of the above theoretical rationale e.g. service user contributes to and signs care plan (RCOGP, 2014), resulting in the therapeutic focus being lost. The LDTC is a complex 24 hour treatment modality. Consequently, it is even more important care is provided flexibly so time spent with service users is effectively used to model healthy reciprocal attachment informed relationships.

3.3 Strengths and limitations

A number of strengths and limitations of the research are considered in the journal article. Additional strengths and limitations are considered here.

3.3.1 Strengths

An important strength of the research is that it represents the first attempt to explore whether the core theoretical principles of TCs, as encapsulated in Haigh's (2013) quintessence principles, exist in a TC environment and identify any additional principles that remain unaccounted for within current TC theory. A second strength of the research lies in the fact the TC principles were investigated in a niche environment with added complexities of the high secure nature of the environment in addition to adaptations to the treatment modality in light of all individuals having a diagnosis of learning disability. Finally, while the research was completed in the form of a single case study, the male high secure LDTC is currently the one in existence. Consequently, the study sampled from the entire population, increasing the representativeness of results produced.

3.3.2 Limitations

A possible limitation of the research is that the interview questions were too scaffolded, influencing participants to respond in a certain way so as to confirm TC principles are evident in the environment when they may in fact not be. However, great care taken with interviews to prevent leading individuals to answer in a specific way (refer to section above on 'suggestibility'). Questions specifically revolving around TC principles were asked in an open format with either/or prompts as needed so as not to lead individuals in their responses. Also, the researcher did not express preference for liking or not liking TC. Finally, the latter section of interview was devoted to exploring other features within the environment of the LDTC.

A second potential limitation of the research may exist in regard to sample bias. Only six out of 12 service users participated. These individuals did not offer any reasoning for their decision not to participate and due to lack of consent, it was not possible to explore demographic information and determine whether these individuals differed in any way to those who participated. The same can be said for the single staff member that was approached but declined to participate in the study. It was common knowledge that one service user who was approached but declined was nearing the end of their treatment on the LDTC. It might be that this individual had consciously separated from community and therefore no longer wished to engage in activities directly related to the LDTC.

In line with TC theory advocating a flattened hierarchy and community membership over polarised roles, the research attempted to consider both service users and staff as one population. However, on reflection it is clear four populations exist; staff participants, staff non-participants, service user participants and service user non-participants. A fifth group may have also been evident in the form of permanent night staff who were unable to be interviewed due to their hours of work. Existence of these various groups may have implications for research findings.

The study only sampled from staff and service user participants and it is possible these two groups were more keen to participate on the basis of interest in the LDTC and thus more compliant in naming TC principles. It is also possible staff participants were motivated to participate due to a desire to carry favour for the LDTC staff team. It is while it is important to acknowledge sampling from other named participant groups would not dismiss the findings of existing participants in terms of the perceived presence of TC principles, it may have allowed for alternative views on these in the LDTC environment.

In addition, the research did not sample from those who were newer to the service and worked across different wards more regularly on the basis on professional advice. It was suggested choosing a sample of more knowledgeable TC members would prove more fruitful in light of the LDTC being complex treatment modality. Those newer to the service may have harboured a more critical stance to the model and been able to convey perceptions of TC principles more objectively due to a lack of need to carry favour with the staff team. Subsequently, the above issues may have further biased the participant sample.

Finally, as previously mentioned within the journal paper, a number of service users had dropped out of treatment. As these individuals had left the hospital and were not able to be invited to take part in study, this may have also affected the generalisability of results and produced further sample bias. However; even if those who did not participate did not recognize the TC principles (which we do not yet know), this data would only have influenced the frequency of themes, not their presence in the interview transcripts.

More specifically, in regard to service user participants, in two interviews, staff members were present, at individuals' requests. It is possible the underlying function of service users requesting staff to be present was to gain good favour with the staff team.

Such reasons could have implications for research findings as the service user may present themselves in a socially desirable way to gain benefits on the ward as opposed to commenting honestly in regard to their day to day experience on the LDTC. Literature on social desirability during data collection in research suggest this factor is often highlighted as evident when there is an under reporting of responses deemed socially undesirable (“I don’t like how staff do this...”) and an over reporting of responses deemed socially acceptable (e.g. “The TC is great”) (Van de Mortel, 2008). However, after examining the interview transcripts, there were no overt differences between service users who attended the interviews alone or with staff. Further, individuals were still able to express a balanced view, evidenced by their communication of likes and dislikes within the LDTC (e.g. “sometimes you can get on well with staff, but sometimes you get in arguments”). The potential influence of staff presence on individuals’ interview content would have been indicated via service users neglecting to offer a more balanced view of the LDTC.

Even so, the motivating factor of social desirability remains important to hold in mind when considering the findings of the research, particularly in light of the given context - a high secure setting where service user participants’ rights are increasingly restricted.

A further limitation of the study was its neglect to explore reciprocity of TC principles more explicitly with staff members. For example, within the interview schedule the research could have enquired further in regard to staff experiences of communication in terms of how open they are with service users and information they choose to disclose or not disclose. Consequently, the research provides limited information on whether and how TC principles work on a two-way basis between service users and staff members.

A final limitation of the research pertains to its design as a single case study, and its 'outlier' status – a case chosen on the basis of its unique and novel nature. In terms of the a priori codes in the deductive content analysis, studying an 'outlier' case strengthens the transferability of the research results as the TC principles are evident, even under unfavourable circumstances. However, in regard to the results of the inductive thematic analysis, the opposite is true.

It is possible additional themes identified within the case study are idiosyncratic and would not be observed in other TCs. This an inevitable consequence of utilizing a single case study design as the single case is 'studied for the lineaments of its structure, its character, with the emphasis on understanding what is going on' rather than aiming to achieve generaliseability of results to wider settings (Thomas, 2011:138). However, use of a single case study design was considered most appropriate in light of no existing exploration of TC principles prior to the study despite the implementation of TCs within varied and complex forensic settings. Therefore the single case study design offered a much-needed opportunity to explore key TC principles amongst other features within the high secure LDTC in more depth.

3.4 Clinical implications

Clinical implications of the research are considered in the journal article. However, clinical implications of the research, specifically in regard to its relevance to clinical psychology, are discussed here.

3.4.1 Relevance to Clinical Psychology

LD and PD client groups remain a challenging and expensive group to treat. Mutli-modal treatments, such as that provided by the TC model, are advocated extensively in existing literature on the treatment of personality disorder.

Ultimately, the LDTC model and additional attributes highlighted within this research may provide a number of benefits for service users and staff teams within forensic learning disability services operating within the confines of secure settings.

The benefits of TCs are reflected in the resurgence in interest in TCs in secure settings, resulting in the recent establishment of TC provisions for those with a diagnosis of learning disability (TC +) at a number of prisons (HMP Gartree, HMP Grendon; NHS England & NOMS, 2015). Therefore the research and its implications have particular relevance for Clinical Psychologists working with this client group.

The core competencies of Clinical Psychologists involve planning and managing service delivery, training and supervision of others. Consequently, Clinical Psychologists are well placed to lead on and support facilitation of the LDTC model at both managerial and staff team levels in forensic settings to develop the use of therapeutically informed environments. More specifically, Clinical Psychologists can be involved in supporting members of the staff team and encourage psychologically informed understandings of learning disability, personality disorder and subsequent behaviour which is very much needed when working with an emotionally provocative client group requiring conditions of high security.

3.4.2 What are the future directions for TCs within learning disability services?

There have been recent calls within the TC literature to move the theoretical constructs of TCs forward by purposefully placing a focus on 'how it works' - what occurs within TCs to identify important therapeutic processes with a view to linking these with outcomes in future research.

The section below on 'outcomes' details how the current study has attempted to move towards this in relation to the LDTC specifically.

3.5 Future research

While avenues for future research were considered in the journal paper, these will be considered in more depth here.

3.5.1 Outcomes

Linking TC principles with outcomes was not an aim of this study. While the evidence base for TC treatment within forensic LD populations remains limited at present, the research literature available provides promising signs around the potential for both staff and forensic LD populations with interpersonal difficulties to benefit from a DTC culture operating within forensic settings.

From what has been established in existing literature and previous research in the area, TCs are not amenable to gold standard RCTs and more dominantly favoured research methods in fitting with positivist stance, resulting in a 'limited' evidence base in terms of outcome studies that comply with such designs. That said, practice-based research on this LDTC specifically, has produced consistently favourable outcomes including reduced intensity of maladaptive schemas, personality disorder pathology and mean seclusion hours compared to baseline measures after two years of treatment (Morrissey & Taylor, 2014).

Consequently, this LDTC was chosen as a basis to explore whether core TC principles actually exist (which has not been investigated previously) and how they are experienced in a novel and niche environment of the high secure LDTC. The research also attempted to build on existing theory by exploring whether any additional elements were evident in the environment.

Future research can begin to make links to outcomes via implementing constructing a tool comprised of a set of statements based on the qualitative data to explore the importance of identified principles in the LDTC environment to staff and service users in future research.

As therapeutic alliance is a known curative factor in group treatment (Budman et al., 1989), exploration of the extent of agreement on important elements in a TC between staff and service users may have important implications for alliances forged and treatment outcome.

3.6 Summary

The idea for the study originated out of identifying an absence of research exploring whether TC principles exist and an over reliance of therapist reflections/experiences on TCs in describing their working features. The results indicate that Haigh's (2013) TC principles are evident within a novel LDTC located in conditions of high security. While there were notable adaptations to the principle of 'agency' in regard to limited employment of a 'flattened hierarchy', previous research in community TCs has identified similar results. Thus, restrictions imposed to the concept of agency are also evident in TCs located outside of high secure environments. Additional principles that were unaccounted for in TC theory were identified by the research.

While some principles appear to map on to patient-centred principles, these features remain specific to this LDTC due to the 'outlier' status of the case study and therefore cannot be generalised to other TCs. Overall, the use of LDTCs have important clinical implications for the future design of services for a forensic male population with dual diagnoses of personality disorder and learning disability.

3.7 Critical reflections on the research process – ethics, scientific issues, theoretical issues.

Reflections on the research process are considered in relation to theoretical, scientific and ethical issues, which arose during the study.

Theoretical issues

The research was inspired by my previous experience of working in a therapeutically informed environment while undertaking employment as a Support Worker in secure inpatient setting for individuals with a diagnosis of personality disorder.

Upon researching the area of Therapeutic Communities, I became aware of an inherent stigma associated with the label 'TC', which appears to be exacerbated by their difficulties in fitting in to the standard of research methodology currently favoured to evidence treatment outcomes, as mentioned previously. From further searching of the literature, it became clear that recent arguments had been posited for trialling an alternative way of gauging treatment efficacy within TCs – a focus on 'what is happening?' rather than 'does it work?'. Undertaking this research was therefore very exciting as it meant I was exploring a novel area with a novel TC (LDTC) with potential implications for the future development and implementation of LDTCs and possibly TCs in general.

However, upon searching and locating existing theory around TCs and therapeutic environments, I began to understand why there has been limited research in to the inner workings of TCs specifically. As there was only one core theory that was the most closely related to TCs (Haigh's [2013] quintessential principles of a therapeutic environment – an update from Rapoport's [1960] themes on TCs), this motivated the need for wider reading around therapeutic environments, curative factors in therapy, therapeutic relationships and systems in order to interpret and understand processes within the LDTC identified by the study. The whole process of locating existing theories to explain the therapeutic features of a TC felt like juggling slippery soap –getting a firm understanding of relevant theoretical literature felt nigh on impossible at times. I began to sympathise with previous researchers' efforts in this area.

While the research reported here highlighted a number of similarities to existing theories on therapeutic environments, systems and indeed patient centred care, this is new knowledge as it is the first time the inner workings of a TC, and LDTC, have been explored and more specifically empirical investigation of the quintessence principles which provide the core theoretical background for DTCs. It also provides support for the existence of Haigh's (2013) principles within a novel TC environment - the LDTC.

From an epistemological perspective, the critical realist position adopted in this research was appropriate as it suited both the aims of the research and my own beliefs on the area of TCs. I believe TCs can be best understood within the frame of critical realism. During the research I became aware that each TC members' experience of the quintessence principles were very much individual. For instance, in relation to the features of their environment they valued most. However, TC members' also harboured a number of similar experiences of the quintessence principles. The critical realist position helped me to consider this in research terms, moving from individual experiences to exploring shared processes, while acknowledging it is not possible to know the complete 'truth' about therapeutic processes within the LDTC.

In line with a critical realist approach, I attended to my own perspective on the research area throughout the process of conducting the study. As I have previously enjoyed working with a therapeutically informed environment and have a longstanding interest in TCs, I found I was taking an insider approach to the research rather than viewing this from the perspective of an outsider. While this provided some benefits, including existing insight in to research in the area and developments in TCs, it limited my ability to adopt an external viewpoint on the process of the study.

Being an insider provided me with easier access to participants as I had existing connections to the high secure hospital, which facilitated easier access to the LDTC. During the interviews it was fairly easy to develop rapport with participants as we had a shared interest, which facilitated discussion.

While I was an insider, with some experience of therapeutic environments, I was not too familiar with the subtleties of an LDTC or indeed its location – within a high secure hospital. In fact, in many ways I felt like I was an outsider to the LDTC as the high secure hospital appeared to have its own powerful sense of community membership and you were quickly alienated from this if you were unable to efficiently glide through security without a hiccup – this was something I never completely mastered. Even so, I felt these experiences helped to maintain my curiosity in the study and prevented my neglect of any important concepts discussed by participants in the LDTC.

Ultimately, supervision remained an important part of the research process by supporting me to continually reflect on my reactions to the research and keep these separate from the analysis. I also kept a research diary containing reflections from the interviews I completed along with other significant events and reactions I experienced during the research process. However, increased use of the diary throughout the study would have aided more in-depth reflections.

Scientific issues

A qualitative single case study design was the most appropriate approach for the research. However, a qualitative approach is not without its challenges. For example, a number of scientific issues can be encountered if there is insufficient engagement in critical reflection throughout the research process (Noble & Smith, 2015). My engagement in critical reflection was particularly pertinent in the development of the interview schedule. During initial formulation of interview questions, I became aware a significant proportion of the schedule had been devoted to exploring the existence of Haigh's (2013) quintessence principles at the expense of investigating any further additional principles inherent in the LDTC.

Through a process of critical reflection I was able to bring this issue to research supervision and gain support in developing a more balanced interview schedule that provided participants with a number of opportunities to discuss additional important experiences that were not necessarily linked with Haigh's (2013) principles. This involved use of questions to inspire lateral thinking. For example, 'If your TC were an animal, what would it be?'

A further difficulty that arose during development of the interview schedule, involved ensuring Haigh's (2013) concepts were more tangible in nature. This task took some time and careful consideration as the quintessence principles specifically focus on implicit nuances of human interaction rather than overtly visible behaviours.

In order to capture the essence of each principle, questions were based around concrete examples from everyday experiences on the LDTC to help individuals consider the enactment of principles within their environment. These conversations were supported with pictures where appropriate. Piloting these principles with a support group for individuals with learning disabilities and their carers in the community, alongside supervision from Clinical Psychologists who specialised in learning disability helped to ensure accessibility of concepts represented in the interview schedule.

Ethical issues

The main ethical issue that arose from the study related to the interviews. Given half of the research sampled from a forensic population with dual diagnoses of both personality disorder and a learning disability, great care was taken to promote individuals' choice in terms of whether they wished to engage in the study. This was accomplished by giving service users ample opportunity to consider participation in the research and ask questions. Information sheets were made accessible to individuals with a learning disability via carefully considered use of language and pictures to represent important concepts.

The information sheets were also piloted with a group of individuals who have learning disability diagnoses to check the accessibility of the information provided. The decisions of those who chose not to participate in the research were respected and upheld. Equally, the same opportunities were provided to staff in terms of time to consider participation, ask questions and ultimately respecting decisions not to participate in the research.

A further ethical issue arose in regard to my role and responsibilities while on the LDTC. Initially, there was some ambiguity around my role on the TC as staff and service users were used to Trainee Clinical Psychologists attending the LDTC for clinical placements. It therefore became important to clarify my role early on, prior to data collection, and remain transparent around the boundaries of my relationships with staff and service users.

I accomplished this by liaising with the TC Manager and together we informed the community of the nature of my role on the LDTC – as a researcher versus a Trainee Clinical Psychologist. This message was further reinforced via information provided on information sheets, which was also discussed prior to participation in interviews. For example, signposting participants in terms of where they could seek support post-interview, should they require this.

Conclusion

In summary, the research process raised a range of theoretical, scientific and ethical issues, which were largely addressed via research supervision. Conducting the research was both fascinating and exciting, particularly as it was such a novel area.

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Appendices

Appendix A – Lincoln University Ethics Committee Approval



Soprec

Fri 18/09/2015, 14:40



Dear Georgina

This is to confirm that your recent ethical approval application was considered and approved by the School of Psychology Research Ethics Committee, pending the following change:

- Addition of soprec@lincoln.ac.uk to the information sheet should participants have any questions around the ethics application

Kind regards

SOPREC



School of Psychology Research Ethics Committee

SOPREC

College of Social Science

University of Lincoln. Brayford Pool, Lincoln, Lincolnshire. LN6 7TS

Email – soprec@lincoln.ac.uk

Appendix B – REC Provisional Opinion – Request for further information letter



Health Research Authority

East Midlands - Leicester Central Research Ethics Committee

The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 883 9275

13 November 2015

Miss Georgina Capone
Trainee Clinical Psychologist - Trent DClinPsy Programme
University of Lincoln
Brayford Pool
Lincoln
LN6 7TS

Dear Miss Capone

Study Title:	Staff and Service Users' Evaluations of therapeutic principles at a High Secure Learning Disability Therapeutic Community (LDTC): A Mixed Methods Study
REC reference:	15/EM/0498
Protocol number:	N/A
IRAS project ID:	179464

The Research Ethics Committee reviewed the above application at the meeting held on 06 November 2015. Thank you for attending to discuss the application.

Provisional opinion

The Committee is unable to give an ethical opinion on the basis of the information and documentation received so far. Before confirming its opinion, the Committee requests that you provide the further information set out below.

Authority to consider your response and to confirm the Committee's final opinion has been delegated to a meeting of the full committee of the REC.

Further information or clarification required

1. Please add access to medical records to the Participant Information Sheet for Service Users and permission to access as a separate point on the Consent Form.
2. Please provide an explanation of the criteria the responsible clinician will use to determine which service users would be part of the 12-15 participants included in the study

3. Please provide an explanation of why all service users will not be given the opportunity to participate.
4. Please ensure there is a documented record of capacity assessment undertaken by a clinician for each occasion the participant will be take part in the study.
5. Please rewrite the Participant Information Sheet for Service Users, the Consent Form and Questionnaires in language appropriate for the community for whom they are intended and have the documents reviewed at an appropriate external service user group which includes people with learning disability
6. Please ensure the following changes are included in the rewritten PIS:
 - a) Take out the reference to 'the research should be fun' at the bottom of page 2 as there is no indication as to why this should be the case
 - b) On page 3, 'What are the benefits of taking part?' the bullet points are leading. Please remove or rewrite in a more neutral tone.
 - c) On page 3, 'What if there is a problem' please add the contact details of a PALS or complaints service external to the ward and research team
7. Please add initial or tick boxes to the Consent Form for each point
8. Please ensure the Consent Form is completed in the presence of a staff member as there may be an issue of varying consent.
9. In the event of the participant becoming distressed and the named nurse not being available, please provide clarification of how the situation will be managed.
10. Please advise whether a private discussion, the Committee queried whether a risk assessment will be undertaken each time the researcher visited the ward.

If you would find it helpful to discuss any of the matters raised above or seek further clarification from a member of the Committee, you are welcome to contact Ellen Swainston at nrescommittee.eastmidlands-leicestercentral@nhs.net.

When submitting a response to the Committee, the requested information should be electronically submitted from IRAS. A step-by-step guide on submitting your response to the REC provisional opinion is available on the HRA website using the following link:
<http://www.hra.nhs.uk/nhs-research-ethics-committee-rec-submitting-response-provisional-opinion/>

Please submit revised documentation where appropriate underlining or otherwise highlighting the changes which have been made and giving revised version numbers and dates. You do not have to make any changes to the REC application form unless you have been specifically requested to do so by the REC.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 13 December 2015.

Summary of the discussion at the meeting

- **Social or scientific value; scientific design and conduct of the study**

The Committee were concerned you proposed to store NHS data on a memory stick and not on a secure server. The memory stick would then be transported to a non-NHS site and patient information obtained from source data stored on a University server.

The Committee said such data which includes forensic history is not suitable for storage on a memory stick.

- **Recruitment arrangements and access to health information, and fair participant selection**

The Committee asked for clarification of the participant data you intend to access as the submission refers only to a 'file'.

You said she would ask the responsible clinician for access to medical records.

You said that any information from medical records would be described generally as a range of offences, for example, and would not be identifiable.

The Committee told you that access to medical records should be explicitly stated in the Participant Information Sheet for Service Users and permission to access stated as separate point on the Consent Form.

In private discussion, the Committee noted the responsible clinician would be responsible for determining which service users would be part of the 12-15 participants included in the study and asked if the decision would be taken on the basis of clinical knowledge.

In private discussion, the Committee suggested 12-15 participants would be an under-representation of service users and asked why all service users would not be given the opportunity to participate.

In private discussion, the Committee noted service users are all inpatients and are vulnerable and were concerned about the potential for coercion.

- **Care and protection of research participants; respect for potential and enrolled participants' welfare and dignity**

The Committee raised concerns about the vulnerability of participants and the potential for psychological and physical harm to both the participants and the researcher.

You said the patients in the Therapeutic Community have the lowest levels of physical aggression in the hospital and are given more trust.

The Committee raised concerns about participants' capacity to consent and the possibility of varying capacity

You said the participants' capacity to consent would be assessed by a nurse and would be on an 'on the day basis.'

The Committee said you should ensure there is a documented record of capacity assessment undertaken by a clinician for each occasion the participant will be take part in the study.

You agreed.

- **Informed consent process and the adequacy and completeness of participant information**

The Committee said the language used in both the Participant Information Sheet for Service Users, Consent Form and Questionnaires to be inconsistent and inappropriate and queried why the PIS was written in the third person. The Committee also considered the pictures used to be unsuitable.

The Committee asked if the Participant Information Sheet for Service Users, Consent Form and Questionnaires had been reviewed by a person with learning disability.

You said they had not.

The Committee asked for the Participant Information Sheet for Service Users, the Consent Form and Questionnaires to be rewritten in language appropriate for the community for whom they are intended and asked for the documents to be reviewed at an appropriate external service user group which includes people with learning disability.

You agreed.

The Committee advised you there were resources available on the internet which would help with formatting the revised documents.

In private discussion, the Committee asked for the following changes to be included in the rewritten PIS:

- a) Take out the reference to 'the research should be fun' at the bottom of page 2 as there is no indication as to why this should be the case

- b) On page 3, 'What are the benefits of taking part?' the bullet points are leading. Please remove or rewrite in a more neutral tone.
- c) On page 3, 'What if there is a problem' please add the contact details of a PALS or complaints service external to the ward and research team

In private discussion, the Committee asked for initial or tick boxes to be added to the Consent Form for each point and said the form should be completed in the presence of a staff member as there may be an issue of varying consent.

- **Suitability of the applicant and supporting staff**

The Committee raised concerns about indemnity as you are not an employee of the trust.

You advised that you have an honorary contract.

- **Suitability of supporting information**

The Committee noted the participants may find some elements of the questionnaire upsetting and asked what support was available for the participant.

You said the participant would be referred to their named nurse.

The Committee were concerned there was a possibility the named nurse may not be on the ward at that particular time and asked for clarification of how the situation would be managed.

You agreed.

The Committee noted the cards to be used in phase 2 of the study would be based on the results of the semi-interviews and reminded you they should be submitted as a substantial amendment to the study when available and prior to their use.

You agreed.

The Committee said the Q Sort was complex and asked if it was suitable to use with this cohort of patients.

You agreed and said it would be clearly explained to participants.

- **Other general comments**

In private discussion, the Committee queried whether a risk assessment would be undertaken each time the researcher visited the ward.

The Committee raised concerns about your safety in a forensic environment and the potential for harm when working with participants who are themselves vulnerable.

The Committee asked where the interviews would take place and whether other staff would be present.

You said the interviews would take place in a sectioned off area. Any walls are clear and there are no doors. Staff will not be present at the interview unless requested by the participant but there will be staff on the ward who will have a clear view of the interview.

The Committee raised concerns that you will, in effect, be alone with the participant and queried whether this would be safe.

You said that you have had induction training including the use of breakaway techniques in the event of an incident. You told the Committee the interview would take place with the participant and yourself at opposite sides of a table which is bolted to the floor. You will have an alarm with you. Both the participant and yourself will have access to an exit point with no door to hinder progress.

Documents reviewed

The documents reviewed at the meeting were:

Document	Version	Date
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Evidence of indemnity letter]	V.1	28 July 2015
GP/consultant information sheets or letters [Draft letter to responsible clinician]	V. 1	25 September 2015
Interview schedules or topic guides for participants [Service user interview schedule]	V.1	25 September 2015
Interview schedules or topic guides for participants [Staff interview schedule]	V.1	25 September 2015
IRAS Checklist XML [Checklist_27102015]		27 October 2015
IRAS Checklist XML [Checklist_27102015]		27 October 2015
Other [Staff demographic data collection form]	V.1	25 September 2015
Other [University ethics approval]	V.1	25 September 2015
Other [Research Supervisor CV - SC]	V.1	03 October 2015
Other [Research Supervisor CV - LB]	V.1	05 October 2015
Other [Demographic information collection - service user participants]	V.1	19 October 2015
Other [Q sort and ranking tasks]	v.1	19 October 2015
Participant consent form [Phase one - service user consent form]	V.1	25 September 2015
Participant consent form [Phase one - staff consent form]	V.1	25 September 2015
Participant consent form [Phase two - service user consent form]	V.1	25 September 2015
Participant consent form [Phase two - staff consent form]	V.1	25 September 2015
Participant information sheet (PIS) [Service user information sheet]	V.1	25 September 2015
Participant information sheet (PIS) [Staff information sheet]	V.1	25 September 2015

[REC Application Form [REC_Form_27102015]	27 October 2015
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Referee's report or other scientific critique report [Research protocol course feedback]	V.1	16 March 2015
Research protocol or project proposal [Research Protocol]	V.1	25 September 2015
Summary CV for Chief Investigator (CI) [CI CV - Georgina Capone]		25 September 2015
Summary CV for supervisor (student research) [Research Supervisor CV - TS]	v.1	07 October 2015

Membership of the Committee

The members of the Committee who were present at the meeting are listed on the attached sheet

The Committee requested this study comes back to full committee

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

15/EM/0498	Please quote this number on all correspondence
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Yours sincerely



Mr Ken Willis
Chair

Email: nrescommittee.eastmidlands-leicestercentral@nhs.net

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments.*

Copy to: *Miss Shirley Mitchell*

Appendix C – REC Approval letter



Health Research Authority

East Midlands - Leicester Central Research Ethics Committee

The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 883 9275

21 December 2015

Miss Georgina Capone
Trainee Clinical Psychologist - Trent DClinPsy Programme
University of Lincoln
Brayford Pool
Lincoln
LN6 7TS

Dear Miss Capone

Study title:	Staff and Service Users' Evaluations of therapeutic principles at a High Secure Learning Disability Therapeutic Community (LDTC): A Mixed Methods Study
REC reference:	15/EM/0498
Protocol number:	N/A
IRAS project ID:	179464

Thank you for your letter of 8 December 2015 , responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair, Vice-Chair and other Committee members..

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Ellen Swainston, nrescommittee.eastmidlands-leicestercentral@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

1. Please make the following amendments to the PIS:
 - a. Page 4 point 2 – reword to say ‘once I have spoken to you and other people in your community, I will make some cards to show the ideas people have had. In the second part of the study I will show these cards to you and talk about them with you.’
 - b. Page 4 ‘Consent’ – reword to say ‘ On the day I come to ask you questions for the first part of the study, and also on the day I show you cards for the second part of the study, I will ask you and someone you trust to sign a piece of paper to say you are happy for me to talk to you about this study.’
 - c. Page 5 ‘what are the risks of taking part?’ – reorder the two sentences so the offer of having a member of staff present is first
 - d. Page 5 ‘What if there is a problem’ – reorder the contact options so that main nurse/doctor is first, followed by advocacy and then researcher
 - e. Page 6 ‘what will I do with what I find?’ – change title to ‘What will I do with the information I get from this study?’

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which you can make available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation’s role in the study is limited to identifying and referring potential participants to research sites (“participant identification centre”), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the

procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Evidence of indemnity letter]	V.1	28 July 2015
GP/consultant information sheets or letters [Draft letter to responsible clinician]	V.2	16 November 2015
Interview schedules or topic guides for participants [Service user interview schedule]	V.1	25 September 2015
Interview schedules or topic guides for participants [Staff interview schedule]	V.1	25 September 2015
IRAS Checklist XML [Checklist_08122015]		08 December 2015

Other [Staff demographic data collection form]	V.1	25 September 2015
Other [University ethics approval]	V.1	25 September 2015
Other [Research Supervisor CV - SC]	V.1	03 October 2015
Other [Research Supervisor CV - LB]	V.1	05 October 2015
Other [Demographic information collection - service user participants]	V.1	19 October 2015
Other [Q sort and ranking tasks]	v.1	19 October 2015
Other [demographic information collection - service user participants]	v.2	16 November 2015
Other [Additional information - points requiring clarification]	V.2	16 November 2015
Participant consent form [Phase one - service user consent form]	V.1	25 September 2015
Participant consent form [Phase one - staff consent form]	V.1	25 September 2015
Participant consent form [Phase two - staff consent form]	V.1	25 September 2015
Participant consent form [Phase two service user consent form]	v.2	16 November 2015
Participant information sheet (PIS) [Staff information sheet]	V.1	25 September 2015
Participant information sheet (PIS) [Service User Information Sheet]	V.2	16 November 2015
REC Application Form [REC_Form_27102015]		27 October 2015
Referee's report or other scientific critique report [Research protocol course feedback]	V.1	16 March 2015
Research protocol or project proposal [Research Protocol]	V.1	25 September 2015
Summary CV for Chief Investigator (CI) [CI CV - Georgina Capone]		25 September 2015
Summary CV for supervisor (student research) [Research Supervisor CV - TS]	v.1	07 October 2015

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

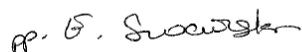
HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

15/EM/0498	Please quote this number on all correspondence
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With the Committee's best wishes for the success of this project.

Yours sincerely



Mr Ken Willis
Chair

Appendix D – REC Minor Amendment approval letter 1



Health Research Authority

East Midlands - Leicester Central Research Ethics Committee

The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 883 9275

04 January 2016

Miss Georgina Capone
Trainee Clinical Psychologist - Trent DClinPsy Programme
University of Lincoln
Brayford Pool
Lincoln
LN6 7TS

Dear Miss Capone

Study title:	Staff and Service Users' Evaluations of therapeutic principles at a High Secure Learning Disability Therapeutic Community (LDTC): A Mixed Methods Study
REC reference:	15/EM/0498
Protocol number:	N/A
IRAS project ID:	179464

Thank you for your letter of 29 December 2015. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 21 December 2015

Documents received

The documents received were as follows:

Document	Version	Date
Participant information sheet (PIS) [Service User Information Sheet]	V.3	22 December 2015

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	Version	Date
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Evidence of indemnity letter]	V.1	28 July 2015

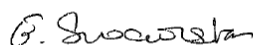
Interview schedules or topic guides for participants [Staff interview schedule]	V.1	25 September 2015
IRAS Checklist XML [Checklist_08122015]		08 December 2015
Other [Staff demographic data collection form]	V.1	25 September 2015
Other [University ethics approval]	V.1	25 September 2015
Other [Research Supervisor CV - SC]	V.1	03 October 2015
Other [Research Supervisor CV - LB]	V.1	05 October 2015
Other [Demographic information collection - service user participants]	V.1	19 October 2015
Other [Q sort and ranking tasks]	v.1	19 October 2015
Other [demographic information collection - service user participants]	v.2	16 November 2015

Other [Additional information - points requiring clarification]	V.2	16 November 2015
Participant consent form [Phase one - service user consent form]	V.1	25 September 2015
Participant consent form [Phase one - staff consent form]	V.1	25 September 2015
Participant consent form [Phase two - staff consent form]	V.1	25 September 2015
Participant consent form [Phase two service user consent form]	v.2	16 November 2015
Participant information sheet (PIS) [Staff information sheet]	V.1	25 September 2015
Participant information sheet (PIS) [Service User Information Sheet]	V.3	22 December 2015
REC Application Form [REC_Form_27102015]		27 October 2015
Referee's report or other scientific critique report [Research protocol course feedback]	V.1	16 March 2015
Research protocol or project proposal [Research Protocol]	V.1	25 September 2015
Summary CV for Chief Investigator (CI) [CI CV - Georgina Capone]		25 September 2015
Summary CV for supervisor (student research) [Research Supervisor CV - TS]	v.1	07 October 2015

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

15/EM/0498	Please quote this number on all correspondence
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Yours sincerely



Ellen Swainston
REC Manager

E-mail: nrescommittee.eastmidlands-leicestercentral@nhs.net

Copy to: *Ms Shirley Mitchell, Nottingham City CCG*

Appendix E – R & D approval letter (including minor amendment)

positive

Nottinghamshire Healthcare 
NHS Foundation Trust

Research and Development
Nottinghamshire Healthcare NHS Foundation Trust
Duncan Macmillan House
Porchester Road
Mapperley
Nottingham
NG3 6AA

E-mail: shirley.mitchell@nottshc.nhs.uk

Date of NHS Permission: 19 January 2016

Miss Georgina Capone
Trainee Clinical Psychologist – Trent DClinPsy Programme
University of Lincoln
Brayford Pool
Lincoln
LN6 7TS

Dear Georgina

Study title: Staff and Service Users' Evaluations of therapeutic principles at High Secure Learning Disability Therapeutic Community (LDTc): A mixed methods study
Sponsor: University of Lincoln
IRAS/REC ID: 179464/15/EM/0498

Thank you for submitting your project to the Nottinghamshire Healthcare NHS Foundation Trust's R&D Department. The project has now been given NHS permission by:

Dr Julie Hankin: R & D Director, on behalf of Nottinghamshire Healthcare NHS Foundation Trust

NHS permission for the above research has been granted on the basis described in the application form, study protocol and supporting documentation. The following documents were reviewed:

Document	Version
Draft Letter to responsible clinician	v2, 16.11.15
Interview guides/topic guides participants (service user interview)	v1, 25.09.15
Interview guides/topic guides participants (staff interview)	V1, 25.09.15
Other (staff demographic data collection form)	V1, 25.09.15
Other (service user demographic information collection)	V2, 16.11.15
Other (Q sort and ranking tasks)	V1, 19.10.15

Other (additional information – points requiring clarification)	V2, 16.11.15
Participant consent form (phase one – service user)	V1, 25.09.15
Participant consent form (phase one – staff)	V1, 25.09.15
Participant consent form (phase two – staff)	V1, 25.09.15

The Resource, Duncan Macmillan House, Porchester Road, Nottingham NG3 6AA
Chair: Professor Dean Fathers, Chief Executive: Ruth Hawkins



INVESTORS
IN PEOPLE | Silver

Participant consent form (phase two – service user)	V2, 16.11.15
Participant Information Sheet (staff)	V1, 25.09.15
Participant Information Sheet (service user)	V3, 22.12.15
Research Protocol	V1, 28.09.15

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP [ONLY if applicable], and NHS Trust policies and procedures available <http://www.nottinghamshirehealthcare.nhs.uk/contact-us/freedom-of-information/policies-and-procedures/>

The research sponsor or the Chief Investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. The R&D Office should be notified within the same time frame of notifying the REC and any other regulatory bodies. All amendments (including changes to the local research team) need to be submitted in accordance with guidance in IRAS.

Please note that the NHS organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research.

Yours Sincerely

Shirley Mitchell
Head of Research and Innovation

cc.

Sponsor

Appendix F – REC Minor Amendment – Approval letter 2



15 February 2016

Miss Georgina Capone
Trainee Clinical Psychologist - Trent DClinPsy Programme
University of Lincoln
Brayford Pool
Lincoln
LN6 7TS

Dear Miss Capone,

Study title:	Staff and Service Users' Evaluations of therapeutic principles at a High Secure Learning Disability Therapeutic Community (LDTc): A Mixed Methods Study
REC reference:	15/EM/0498
Protocol number:	N/A
Amendment number:	MA02
Amendment date:	12 February 2016
IRAS project ID:	179464

Thank you for your letter of 12 February 2016, notifying the Committee of the above amendment.

The Committee does not consider this to be a "substantial amendment" as defined in the Standard Operating Procedures for Research Ethics Committees. The amendment does not therefore require an ethical opinion from the Committee and may be implemented immediately, provided that it does not affect the approval for the research given by the R&D office for the relevant NHS care organisation.

Documents received

The documents received were as follows:

Documents received

The documents received were as follows:

Document	Version	Date
GP/consultant information sheets or letters [Draft Letter to RC - Tracked]	3	12 February 2016
Notice of Minor Amendment [Email from georgina Capone, University of Lincoln (student)]	MA02	12 February 2016

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for

Research Ethics Committees in the UK.

15/EM/0498:	Please quote this number on all correspondence
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Yours sincerely



Nicola Kohut
REC Assistant

Email: nrescommittee.eastmidlands-leicester@nhs.net

Copy to: *Ms Shirley Mitchell, Nottingham City CCG*

Appendix G – R & D Minor Amendment Approval Letter (email)



Mitchell Shirley - Head of Research and Innovation <Shirley.Mitchell@nottshc.nhs.uk>

Fri 26/02/2016, 08:24

Georgina Capone (14498804); Morton Sally <Sally.Morton@nottshc.nhs.uk> ▾

Inbox

Flag for follow up.



Draft letter to Responsi...

1 MB



Download Save to OneDrive - University of Lincoln



Action Items

Hi Georgina

Thanks for the updated document, I acknowledge receipt of the amendment.

Sally, I am not sure if you have put the documents on documas, if so could you add the attached.

Thanks both.

BW

Shirley

Shirley Mitchell
Head of Research and Innovation
Nottinghamshire Healthcare NHS Foundation Trust
Duncan MacMillan House

Appendix H – REC major amendment approval letter: Removal of Q sort from research design



Health Research Authority

East Midlands - Leicester Central Research Ethics Committee

The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.

07 March 2017

Miss Georgina Capone
Trainee Clinical Psychologist - Trent DClinPsy Programme
University of Lincoln
Brayford Pool
Lincoln
LN6 7TS

Dear Miss Capone

Study title:	Staff and Service Users' Evaluations of therapeutic principles at a High Secure Learning Disability Therapeutic Community (LDTC): A Mixed Methods Study
REC reference:	15/EM/0498
Protocol number:	N/A
Amendment number:	SA1
Amendment date:	15 February 2017
IRAS project ID:	179464

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Notice of Substantial Amendment (non-CTIMP)	SA1	15 February 2017
Research protocol or project proposal [Clean]	2.0	10 February 2017

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

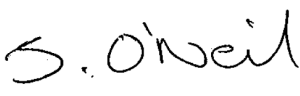
Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our Research Ethics Committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

15/EM/0498:	Please quote this number on all correspondence
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Yours sincerely

pp. 

Mr Ken Willis
Chair

Appendix I – HRA Approval: Removal of Q sort from research design

From: AMENDMENTS, Hra (HEALTH RESEARCH AUTHORITY) <hra.amendments@nhs.net>
Sent: Wednesday, 15 March 2017 15:41
To: 14498804@students.lincoln.ac.uk
Cc: Mitchell Shirley - Head of Research and Innovation; LEICESTERCENTRAL, NRESCommittee.EastMidlands- (HEALTH RESEARCH AUTHORITY)
Subject: RE: IRAS 179464. Confirmation of Amendment Assessment

Dear Miss Capone

Further to the below, I am pleased to confirm that HRA Approval has been issued for the referenced amendment, following assessment against the HRA criteria and standards.

The sponsor should now work collaboratively with participating NHS organisations in England to implement the amendment as per the below categorisation information. This email may be provided by the sponsor to participating organisations in England to evidence that the amendment has HRA Approval.

Please contact hra.amendments@nhs.net for any queries relating to the assessment of this amendment.




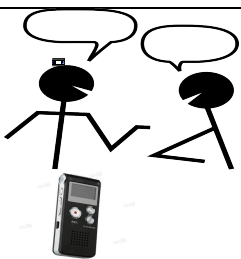

Kind regards
Joanna





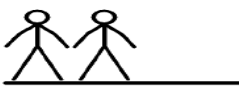



Joanna Strickland | Assessor
Health Research Authority
Bristol HRA Centre, Level 3, Block B, Whitefriars, Lewins Mead, Bristol, BS1 2NT
E: joanna.strickland@nhs.net | T: 0207 104 8048
www.hra.nhs.uk

CONSENT FORM (SERVICE USERS)– Part One

Title of Study: Staff and service users' evaluations of therapeutic processes within a high secure learning disability therapeutic community (LDTC): A mixed methods study

		Please	
		YES	NO
	George has explained to me about the study		
	I understand the information sheet		
	I understand George will access my medical records to collect some information about me		
	I understand George will talk with me about my experience in the community and that our talk will be recorded on a tape.		
	I understand an admin lady in the hospital will make notes on this and delete the recording in one month.		

	I understand George's teachers at the university might look at the notes she has made		
	I understand George will publish information gained from my taking part in this study and know my name will be removed from this.		
	I understand it is my choice to say YES or NO to take part in the study		
	I know that I can change my mind about taking part and can remove my information up to one week after taking part in the study		
	Somebody I know was here with me when I signed this form		
	I agree to take part in part one this study		

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Nurse	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

Participant identifier:_____

Appendix K – Staff consent form

CONSENT FORM (STAFF) – Part One

Title of Study: Staff and service users' evaluations of therapeutic processes within a high secure learning disability therapeutic community (LDTC): A mixed methods study

Name of Researcher: Georgina Capone

Name of Participant:_____

Participant identifier:_____

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.
2. I understand that my taking part is voluntary and that I am free to stop at any time, without giving any reason, and without my employment being affected. I understand I can withdraw my data up to one week after engaging in part one of the research. After one week, I am aware any information collected cannot be removed and this information may be used in the study.
3. I understand authorised members of staff from the University of Lincoln may look at demographic data and information collected in the study. I give permission for these individuals to have access to this information and to collect, store, analyse and publish information obtained from me taking part in this study. I understand my personal details will be kept confidential.
4. I understand that the interview will be audio recorded, that the recording will be transcribed by an administrator in the hospital and destroyed within one month.
5. I agree to take part in **part one** of the above study.

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Researcher	Date	Signature

Appendix L – Staff information sheet

Participant Information Sheet

Title of Study: Staff and service users' evaluations of therapeutic processes within a high secure learning disability therapeutic community (LDTC): A mixed methods study

Name of Researcher: Georgina Capone

You are invited to take part in this research study, conducted as part of the Trent Doctoral Research Programme. Before you decide whether or not to participate, it is important you understand why the research is being done and what it will involve. Please take time to read over the information provided below and discuss it with others if you wish. If you have any questions about the study and would like further information please contact the researcher who will be happy to answer any queries.

What is the purpose of the study?

Existing theory on processes occurring within therapeutic communities (TCs) have mainly developed from a practitioner perspective and provide a general explanation of the inner workings of all TCs, despite their use in a variety of complex and specialist settings. While your community has been found to produce positive therapeutic change for individuals, current research and theory is unable to specifically account for the TC processes experienced by TC members (particularly service users) within this unique treatment setting and the value of these features to individuals. The purpose of the investigation is to increase understanding of key TC features and their value to staff and service user TC members in this LDTC.

Why have I been invited?

The aim of this research is to explore staff and service users' experiences of this therapeutic community. You are being invited to take part because you are a TC member and work within this therapeutic community. In the first stage we are inviting up to 7-8 people like you to take part.

In the second stage, we are inviting 40 people like you to take part. You will need to have worked in the TC for three years or more and be able to communicate and understand verbal/written English to engage in the study.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This will not affect your legal rights.

What will happen to me if I take part?

There are two parts to this research. If you take part in the first part of the research, you will be invited to complete an interview with the researcher. This should take no longer than an hour. You will only need to meet the researcher once to complete the interview. During the interview you will be asked about your experience of working in this community.

The second part of the research will take part on a separate occasion. You can still engage in this part of the research if you did not engage in the first part of the study. If you decide to take part in this stage of the research, you will be invited to complete a simple ordering task – ranking a series of statements. The task would last up to an hour. You will only need to attend once to meet the researcher and complete this task.

Both parts of the research will be audio recorded. An administrator in the Hospital will transcribe the recordings after signing a confidentiality agreement. Recordings will be destroyed within one month of creation. The study will take place at the Hospital at a mutually agreed time and place. The researcher will ask you to complete a demographic data collection form if you engage in either part of the study. The demographic information (age, professional role, time employed on LDTC, completed TC training) collected will be anonymised (name removed) and used to provide a general description of individuals who participated in the study.

What are the possible disadvantages and risks of taking part?

There are no identified risks of taking part in this study. However, the researcher will ensure you are aware there is no obligation to complete any aspect of the research you do not wish to or provide reasons for this. If you do experience distress as a result of this study we will be able to offer you advice and support within the study debrief.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study may help develop existing theory on TCs, further inform treatment for service users, and the training of staff members within such settings.

What if there is a problem?

If you have any problems relating to the interviews or ordering task, or any further questions, please contact the researcher - Georgina Capone via the contact details listed below. A comments box will be provided to post any queries about the study while the researcher is absent, and these will be followed up at the earliest opportunity.

If you remain unhappy and wish to complain formally, you can do this by using the comments box provided or by writing to Thomas Schroder (Nottingham University Course Director), using the contact details below. Any questions around research ethics can be directed to soprec@lincoln.ac.uk.

Will my taking part in the study be kept confidential?

All information collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password-protected database. All audio material collected by the investigator conducting the interviews. A member of the administration team in the Psychology Department will sign a confidentiality agreement prior to transcribing the audio material.

Any information about you that leaves the hospital will have your name removed (anonymised) and a unique code will be used so that you cannot be recognised from it. Only authorised persons will be able to access the anonymised data (Investigator – Georgina Capone, Louise Braham, Simon Clarke & Thomas Schroder – University of Lincoln and Nottingham staff).

They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All research data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data. Although what you say in the interview is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

What will happen if I don't want to carry on with the study?

Nothing will happen. Your participation is voluntary and you are free to withdraw at any time, without giving any reason. For both parts of the research, you are free to take away your data up to one week after engaging in the interview/ordering task. You can request to withdraw your data by contacting the researcher at the email address located below quoting your code (this will be on your consent form). After one week, the information collected so far may not be removed and may be used in the study. Your employment will not be affected if you choose not to carry on with the study.

What will happen to the results of the research study?

The researcher intends to submit the findings to a peer-reviewed journal to publish the results. Paper copies of this will be delivered to the LDTC and made available to all TC members. The research findings will then be presented to all members of the LDTC. In order to ensure you cannot be identified in any publications, pseudonyms will be used and any references to personal information will be changed.

Who is organising and funding the research?

This research is being organised and funded by the University of Lincoln.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Leicester Research Ethics Committee.

Further information and contact details

Georgina Capone (Researcher)

Email: 14498804@students.lincoln.ac.uk

Nottingham University Course Director:

Thomas Schröder (Associate Professor in Clinical Psychology and Chief Investigator)

Email: Thomas.schroder@nottingham.ac.uk

Address: Doctorate in Clinical Psychology

B Floor Yang Fujia Building

Jubilee Campus

Wollaton Road

Nottingham

NG8 1BB

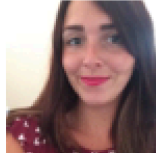
Appendix M – Service user information sheet



Participant Information Sheet

Title of Study: Staff and service users' evaluations of therapeutic processes within a high secure learning disability therapeutic community (LDTC): A mixed methods study

Hi I'm George.



- I would like to invite you to take part in a research study, which is part of a course I am doing to train as a Clinical Psychologist.
- I would like you to understand why the study is happening and what it would mean if you took part.

Why is the study happening?

I would like to try and understand how your community works for people living in it.

Why have I been invited?

- I would like to ask you some questions about what its like to live in your community.
- I will invite everyone who lives in the community to take part in the research.



Do I have to take part?

No. It is up to you to choose whether or not to take part.



What will happen to me if I take part?

There are two parts to this study.

1. If you take part in the first part of the study, I will ask you some questions about your life in the community. This should take no longer than an hour.
2. Once I have spoken to you and other people in your community, I will make some cards on ideas people have had. In the second part of the study, I will show you these cards to you and talk about them with you.



Your permission

On the day I come to ask questions for the first part of the study, and also on the day I show you cards for the second part of the study, I will ask you and someone you trust to sign a piece of paper to say you are happy for me to talk to you about this study



Recording

- I will record both parts of the study. This means I will switch on a machine to record what we talk about together. I will keep this recording safe.
- An admin lady who works in the hospital will write notes on what we talked about and keep this information safe.
- The recording will be deleted in one month.
- My notes will be kept in a safe place and your name will be removed from the notes.



Your medical records

- I will ask to look at your medical records if you take part in the study.
- This is because I would like to collect some information to describe people who took part in the study (your age, your index offence, how long you have lived in the TC and at Rampton Hospital, and



Risks when taking part?

- If you would like a member of staff to be with you that is fine.
- Some of the questions I ask could make you feel upset.
- If you feel upset and want to stop taking part that's fine too.

**Good things about taking part?**

1. The information I collect may help people to understand how the community works.

**What if there is a problem?**

If the study has upset you, you can:

1. Talk to your main Nurse, Doctor, or clinical team
2. Speak to advocacy services – contact number: 7569/7392
3. You can ask me to come and visit you to explain any questions

**Will what I say be kept safe?**

- All information collected from you will be kept in a safe place and locked away.
- Your name will not be attached and no one will know the information is yours.
- I will make sure when I write up the research and talk about it that no one will recognise you from this.
- My teachers at the university may ask about the information and will have access to the information you provided but will not know your name.
- Your name will not leave this hospital.



What if I don't want to carry on with the study?

You can stop at any time. You can ask for your information back or ask me not to use it within one week of taking part in the study.

**What will I do with the information I get from this study?**

I will publish what I find in a paper. I will also talk to the community about what I have found.

**Further information and contact details**

- You can contact me by asking your main Nurse to contact the Psychology department.
- If you are worried about how the study is being run, you can ask staff to contact a group of people who work at my university.



Appendix N – initial interview schedule

Interview Schedule –TC Staff

1. Tell me about the TC

- What is the atmosphere like?
- How does it compare to other places you have worked?

1. Attachment and Containment (Haigh)

- Lets talk about your relationships with people in the TC. Can you tell me about the relationships you share with other TC members? (Who do you have relationships with? What are they like? Tell me more about that. How does this compare to other places/wards you have worked on?)
- What happens when someone is distressed (Can you recall a specific example? Tell me more about that. How did others react? What happened after that?)
- What happens when someone breaks a community rule? (Can you recall a specific example? Tell me more about that. How did others react? What happened after that? How are TC members made aware of the rules?)

2. Communication (Haigh)

- Tell me about how people talk to each other in the TC (tell me more about that, when, what, where, how, how often?)
- What do people talk about? (Are people able to speak their minds or do you think people keep things to themselves? Effects of this, if any?)

3. Involvement and inclusion (Haigh)

- What kind of things do people do within the TC? (What does this involve? Who is invited? Who joins in? How often? How does this compare to where you have worked before?)
- What happens when people do not participate? (Can you think of a recent example? Tell me more. Who? What? Where? When? How?).

4. Agency (Haigh)

- Who has responsibility within the TC? (Who makes decisions? How are decisions made? Tell me more.)
- What kind of responsibility do service users have? (When? Where? How? Tell me more. How does this compare to other places you have worked in?).

5. Additional features

- What do you like best about your community?
- What do you hate about your community?
- Is there anything else you have experienced within the TC that we haven't spoken about? (What happens? Where? When? How? How often? What does this mean to you?)
- How would you describe the TC to a friend? (What would you say?)
- What do you think about visitors who come to the TC? (How often do they come to the community? How does it make you feel?)
- What are the consequences of this if any? (Effects for service users? Staff? The community?)
- What do you think about part time staff that work on the TC? (Tell me more)
- What are the consequences of this if any? (Effects for service users? Staff? The community?)
- If your community were an animal, what would it look like?
 - What would it sound like?
 - If you could draw it, what would it look like?
 - If your community were a song, what would it be?

Appendix O – service user interview schedule

Interview Schedule –TC Service Users

1. Tell me about your community *(picture)*

- What happens in your community?
- How many people live here?
- Is it loud or quiet? Why? *(picture)*
- Is it a sad or happy place? Why? *(picture)*
- Is it different or the same to the place you lived before? Why? How is it different/the same?
- Do you like it or not like it? Why/Why not?

2. Attachment and containment (Haigh) – *(picture – staff and other people)*

Tell me about the relationships you have with people on the TC

- Who do you have relationships with?
- Are they all the same or different? Why?
- How long have you had the relationships for?
- Do you like having these relationships or not like it? Why?
- Do these relationships make you work hard or are they easy?
- Are the relationships important or not important to you? Why?
- Are the relationships you have with people here the same or different to the last place you lived?

What happens when someone is upset? *(picture)* (Can you remember a time in the last week?)

- Who comes to help this person? (do staff come to help? Do patients come to help?)
- Did people shout or stay calm?
- Do you think this is good or not so good? Why?

What happens if someone breaks a rule?

- Do people shout or stay calm?
- Do you know what the community rules are?
- Do you think the rules are clear or not very clear?
- Do you think the community is strict or not strict?
- Are the rules the same or different to the last place you lived? Why?
- Do you like this or not like this? Why?

3. Communication (Haigh)

How do people talk to each other in your TC? (picture)

- What do people talk about?
- Do people say what's on their mind or do they keep it to themselves? (What about staff? what about patients? Is it different or is this the same?)
- How do people talk to someone who is sad? (are people kind or are they cross? Do people talk to each other with respect or not?)
- How do people talk to someone who is cross? (are people kind or are they cross? Do people talk to each other with respect or not?)
- Where do people talk to each other?
- Do people talk at a special place and time or wherever they like?
- Do people talk in groups together or on their own?
- Does this happen a lot or not very much?
- Do you like how people talk to each other in your community or not like it? Why?

4. Involvement and inclusion

What kind of things do you do in your TC? (picture)

- Who is invited? Who joins in? (Staff? Patients? Both?)
- Do you do spend a lot of time together or do you spend most of your time on your own?
- When you do things in your community do lots of people join in or only a few?
- Is this all the time or only sometimes?
- Do people have to come or do they get to choose?
- What happens if people do not join in?
- What kind of things did you do at the place you lived before?
- Who joined in?
- Was it different at the place you used to live or the same?
- Do you like this or not like it? Why?
- Do you feel like you are part of this TC or not? Why/Why not?

5. Agency

Who has responsibility in the TC? (*picture*)

- Who makes decisions about things that happen on your TC? (staff, patients or both?)
- How are decisions made? (do people vote or does one or two people decide on their own?)
- Are all decisions made the same?
- Do all people in the community have responsibility or just a few people?
- Can you make decisions or do other people make them for you?
- What do you do if you have an important decision to make? (do you ask someone for help or do you make the decision on your own?)
- Is the way people make decisions the same or different from the place you lived before? Why?
- Do you like this or not like it? Why?
- Do you have a special role in the TC? What do you do?
- Do you like this or not like this? Why?

6. Additional features

- **What do you like best about your community?**
- **What do you hate about your community?**
- **Is there anything else that is important about your community that we haven't spoken about?** (What happens? Where? When? How? How often?)
 - Do you like this or not like this? Why?
 - How would you describe the TC to your friends?
 - Would you encourage them to live here or not? Why?
- **Who visits your community?**
 - What do you like or not like about them? Why?
 - Do you think it's okay to have visitors on the TC or do you not like this? Why?
- **What do you think about staff who do not work in the community all the time?**
 - Do you think this okay or do you think these people should work in the community all of the time? Why?
- **If your community were an animal, what would it look like?**
 - What would it sound like?
 - If you could draw it, what would it look like?

- If your community were a song, what would it be?

Appendix P – Inductive coding example

The comments on the right hand side relate to step one of the analysis. The numbers on the left hand side relate to step four with the numbers corresponding to specific themes.

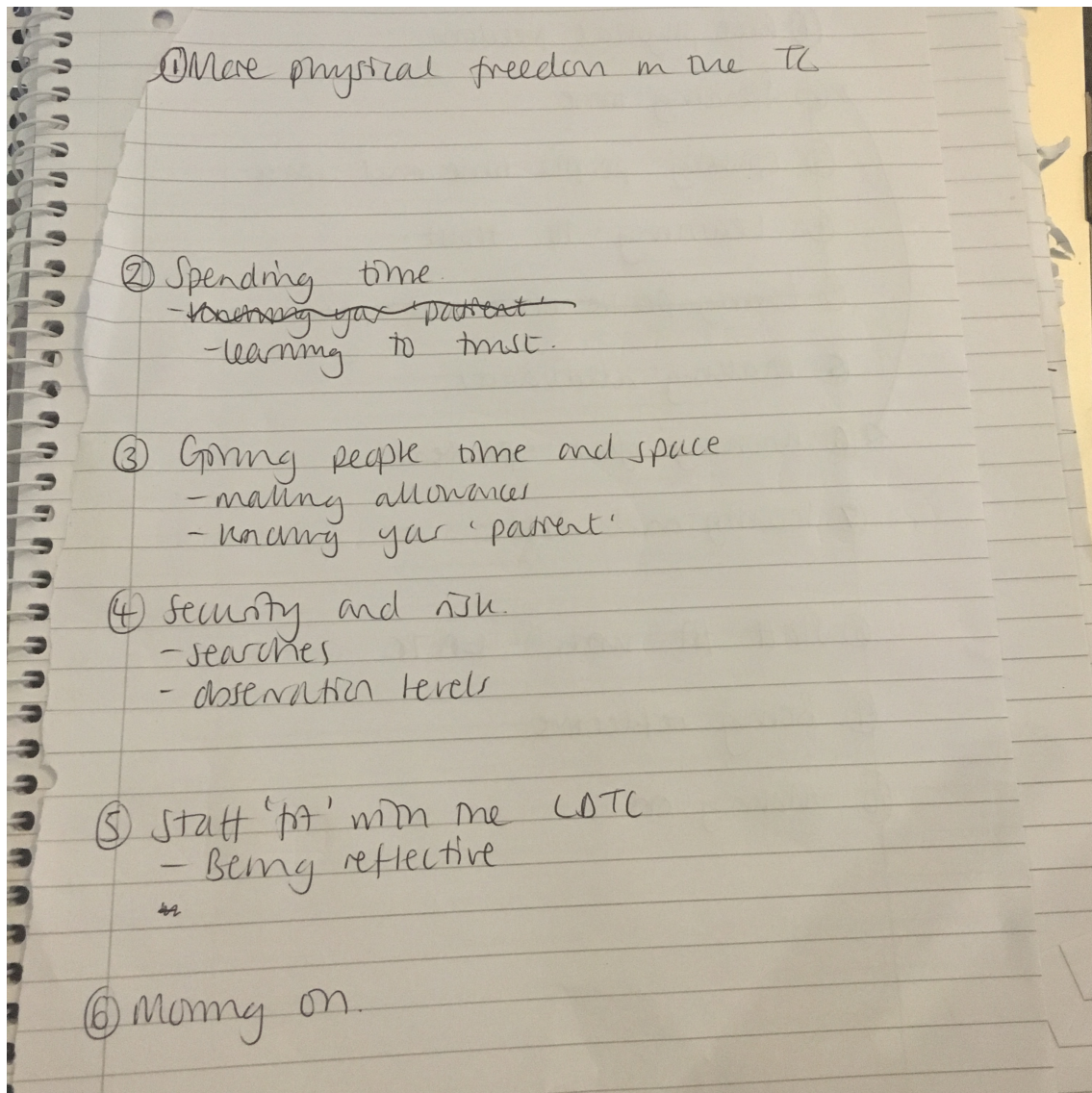
Inductive data		Code
<i>Patient excerpts</i>		
P1: 1	No, if you was on another ward you probably won't get much freedom like you do on the TC. Like on the TC you can go to your room when you want. Yeah, get drinks and snacks whenever you want. Like on some other wards you got like certain times when you can get drinks.	Freedom to move around/get drinks in the TC.
2	Compared to other wards probably because they're not busy doing other things and that can spend more time here	Staff have more time to spend with patients.
2	But on the TC you've got staff who just spend time being around patients, care for patients instead of being somewhere else, i.e. like office or kitchen, as long as you've got a member of staff being with you in the day-room or corridor to talk to.	Staff spend time with patients.
3	Yeah but some days you might find it hard, like on this ward you have to talk about what's troubling you straight away and then you can talk or we'll give you a bit of space and time and then you can talk when you're ready, not there and then but on other wards probably get told no you need to talk it now.	Staff give patients space and time to talk.
3	It all depends what kind of mood you're in, if you're not in a good mood you want to be alone then, patients respect that and give you a bit of space. Yeah, even if they're going through a rough time, when you're back from the group and you go to your room and when you come back out and that person who's the same group as you asks how you're feeling and you say to that person that you're not feeling alright, then that person gives you a bit of space and if that person sees someone else trying to keep asking then that person who's asking are you feeling alright and that person no you're not, then that person tells the other person just to leave you alone.	<p>Patients give patients time and space.</p> <p>Patients remind others to give</p>

		people space when they need it.
1	You can go to your room whenever you want. Go to your room whenever you want or get a drink when you want and that. And also doing your washing anytime you want. But like on other wards you've got like slot times when you can use the washing machine, but on here you can use it when it's free or whenever you want to use it.	Freedom to move around/do washing in the TC.

Appendix Q – Process of reviewing themes

Initial list of themes

These were recorded from each of the transcripts and collated in to potential themes. The numbers represent a first attempt to organise the themes.



Reviewed list of themes

① More physical freedom in the LTC

TRUST

- ② Spending time
- ~~knowing your 'parent'~~
 - learning to trust.

RESPONSIBILITY

- ③ Giving people time and space
- making allowances
 - knowing your 'parent'
- ④ Security and risk
- searches
 - observation levels

⑤ Staff 'PA' with me LTC

~~Being reflective~~

⑥ Being reflective

⑦ Moving on

Appendix R – Table of themes and salience

The below table represents themes (concepts considered both important and recurrent), and subthemes (concepts neither highly important or recurrent) identified within the saliency analysis.

Theme	Staff responses (%)	Patient responses (%)	Overall response rate (%)
Security and risk	83 % (5)	33 % (2)	58 % (7)
Observations	0 % (0)	33 % (2)	17 % (2)
Searches	50 % (5)	0 % (0)	25 % (5)
Trust	83 % (5)	67 % (4)	75 % (9)
Learning to trust	33 % (2)	50 % (3)	42 % (5)
Staff spend more time	67 % (4)	17 % (1)	42 % (5)
More Physical freedom	67 % (4)	83 % (5)	75 % (9)
Responsivity	83 % (5)	67 % (4)	75 % (9)
Knowing your patient	67 % (4)	0 % (0)	33 % (4)
Making allowances	33 % (2)	33 % (2)	33 % (4)
Giving people time and space	0 % (0)	50 % (3)	25 % (3)

Appendix S – Deductive analysis – example quotes

Attachment

Service users:

[...] you feel safe, you feel secure, it just feels like a family.

[...] staff on here treat you like a human being.

Staff:

[...] I mean like I say relationship wise there is a lot stronger bond now between the patients themselves and the staff and patients.

Containment

Service users:

[...] basically people can help and support you when you go through bad things or hard things.

Staff:

[...] I like that we're not intervening and controlling situations maybe like other wards do to a far greater degree, you tend to feel quite proud that you're not intervening, it's quite difficult because it's not an easy decision not to control, the easy thing to do is to control a situation, manage it, stepping back and having the confidence to step back and take that calculated risk but it is a calculated risk but backed up by a relationship and knowledge of patients so I like that.

Communication

Service users:

[...] Here the patients ask you questions like why did you do it or can you explain to me what made you do it and you explain it and that.

[...] On here you can tell them what you've done. Yeah, you can talk about your offences on this ward yeah but if you talk about your offences on the [separate ward] then you get beat up. I think it's a good thing because you've got to get it out somehow haven't you...I talk about it often since I've been on here and it's more better for me to talk about it.

Staff:

[...] I like the fact that they're able to challenge each other...so basically if a patient was to do something wrong or what's perceived as wrong by other people...they get challenged at the time by the staff but then we'll put them in the book, community book, agenda book, so then in a community meeting that obviously gets raised so they get challenged by their peers as well, so it's, obviously the staff will challenge them at the time but it will come about again where they get challenged as well.

[...] but I do think that they believe that they can come to us with anything and talk to us and some of them do open up about some things that they probably wouldn't do anywhere else, so they obviously feel safe enough to do it which is a good thing.

[...] Suppose with the patients, I don't know, just feel more comfortable, more at ease and I think I see it as a two-way thing, you know, with the patients, I think I've got a better relationship with them than previously, just through talking to them more, through working together in the groups, having one-to-one sessions etc., just feel that you've got a stronger relationship with the patients on here than I would have had previously, more opportunity to talk, it's more open, whereas previously it wasn't so encouraged to have that openness twenty-four hours a day, you know, it was more of a do all the therapy off the ward elsewhere with other people and come back and we would never become involved with that side sometimes.

Involvement and inclusion

Service users:

[...] When you break a rule you could be day-room bound, you'll go into the community book to talk about it, that would be on a Monday or a Friday group, then it could be taken to your Wednesday group where you could talk about it more in-depth or it depends on the situation.

Staff members:

[...] Depending which rule, if they just don't go to a TC activity they have their room locked off for the rest of the day and they can't attend social functions that day. They're only observed in the day-room if it's kind of medication that they're refusing just obviously as I said about their mental state or if they're bullying, if they're bullying one another the verbal abuse then we'll be with them to monitor that.

Agency

Service users:

[...] We make the rules on here. It's a good thing.

[...] Mainly staff and us. If we're not happy with something we can put it in the book [community agenda book].

Staff:

[...] It does, yeah it does, they're the first to grass on everybody, it's weird really because they will try it on themselves, you know try and break a rule, but they're the first to come and tell you when somebody else has tried to break a ward rule so it's good because they're all watching each other and making sure that they're not breaking a rule but they maybe try it themselves but somebody else is watching them to break a ward rule as well so it's good.

Appendix T – Coding template

Concepts	Definition	Coding rules	Example
Attachment	Community members (refers to patients and staff) experience a sense of belonging and feel valued by other members.	Responses indicating the community member experiences a clear sense of belonging to the TC and/or feels valued/ respected by those within it.	<p>“It’s different here. We treat each other like human beings and staff call you by your first name”.</p> <p>*NOT related to examples involving peer pressure</p>
Containment	<p>Community members have the chance and space to express intense emotions and have these validated and accepted by other members.</p> <p>Community members are aware of the boundaries of what is and is not permitted in the community</p>	Responses referring to examples of <i>valued support offered by other community members during times of distress</i> , opportunity and space to display and experience intense emotions without immediate staff intervention, and awareness of the limits of what behaviour will be tolerated by the community.	<p>“We give patients the space to shout and vent what’s on their mind. Or even let them have a heated argument with another peer. It’s about knowing when to stand back and when to intervene”.</p> <p>“Staff and peers support you when you’re having a tough time. It’s good to talk. We can have a 1:1 at any time with another patient or staff member”..</p>
Communication	A culture of openness is promoted. Communication is more open, honest	Response indicates the individual feels safe in the fact the community will accept and digest what they	“You can talk about your offences on here. People encourage you to. If you tried

	and profound than happens in everyday situations.	have to say and/or regular opportunities are available for enquiry, commentary and questioning of others (staff and patients') actions.	to do that on other wards, you'd get beaten up by patients for it". "Staff can be challenged by patients as well as patients being challenged by staff".
<i>Involvement and inclusion</i>	Everything that occurs within the community (e.g. from therapy groups, to making a cup of tea) is considered part of therapy and creates material to be discussed by community members. Others are meaningfully defined via a social process (i.e. how others experience them).	<i>Response refers to promotion of inclusion/involvement via peer pressure, rules and procedures (e.g. community meetings) and/or by staff intervention.</i>	"We've made a rule that if you don't come to community meeting you get locked out of your room until 9 pm. Your name will be put on the agenda for the next community meeting and it will stay there until you talk to everyone about why you didn't want to come" (patient).
<i>Agency</i>	Emphasis on the network of relationships over social hierarchy. Authority is fluid and questionable. Responsibility is shared between patients and staff within specified limits.	<i>Examples refer to instances where responsibility is shared (e.g. voting, the way in which decisions are made), members take responsibility for each other (e.g. tell peers/staff when they have broken a community rule), their own recovery or more generally where community members are empowered to take whatever action is</i>	"We all make the rules together (patients). Patients and staff sit together on a rule committee as well to discuss any new rules and see whether they get the final okay or not". "We all have to vote on whether a patient leaves the

		required (e.g. staff give decisions back to the community to make – “it’s your community, it’s up to you”).	community, if they say they want to go”. “It’s up to me to make changes for myself”
Other	Content considered unrelated to the research questions.	Responses describing material unrelated to TC principles (e.g. wider goings on in the hospital) or other important elements in the surrounding environment.	“I’m a strong guy, I’ve caused a lot of damage. Everyone knows not to cross me”. “It’s a really good TC. It really works, you know”.
<u>Inductive Thematic Analysis</u> – insert further themes below			
Trust			
Security & Risk			
External Opinion			
Willingness Responsivity			

Appendix U – Journal submission guidelines

Please see the following link:

http://emeraldgrouppublishing.com/products/journals/author_guidelines.htm?id=tc

Appendix V – Email from journal editor

From: Georgina Capone (14498804)
Sent: 21 November 2016 11:34
To: Gary Winship
Subject: Journal paper

Good morning!

I hope you are well. I am currently in the midst of editing a journal paper on a case study of a TC (based on my doctorate research) and hope to submit this to the International Journal of TCs. Unfortunately, I am faced with a dilemma in that my paper is beyond your word count (currently around 7,500 excluding references) due to having two levels of qualitative analysis (a deductive content analysis and thematic analysis). I wondered if there was any flexibility in terms of whether you would accept a paper beyond your word count of 5,000?

I look forward to hearing from you.

Many thanks,

Georgina Capone



Gary Winship <Gary.Winship@nottingham.ac.uk>

Wed 23/11/2016, 05:46



We do have some scope, but you would need to sustain quality to justify the extra length. By all means submit it if you feel that you need to have the length, and we can see what reviewers say.

Dr Gary Winship

Associate Professor, School of Education, University of Nottingham,

Senior Fellow, Institute of Mental Health.

Universities Psychotherapy & Counselling Association Training Standards Chair.

Chair of appointments panel Skellern Lecture: www.skellern.info

AHRC grant holder: www.claytransformations.info

website: www.winship.info

Appendix W - Extract from research diary

11.08.16

Upon reading through and coding the transcripts, I became aware of coding overinclusively by putting significant amounts of data in pre-existing categories defined by the template. This is leaving little room for more purposeful and critical questioning of the data to explore whether anything new is represented in the interview transcripts, besides TC principles. I will discuss this in my next supervision to gain support on taking more of an 'outside' perspective on my data.

Evaluations of a Learning Disability Therapeutic Community (LDTC)

Georgina Capone – TrentDClinPsy – University of Lincoln

Background: Existing theory on TC processes has developed from a practitioner perspective, avoided empirical testing and maintained a generic focus despite implementation of Therapeutic Communities (TCs) in specialist forensic settings. Although a novel LDTC located at a High Secure Hospital, has been evidenced to improve interpersonal difficulties, current research and theory is unable to imply whether suggested theoretical processes exist in this community or their importance to TC members (staff and service users) in facilitating a supportive therapeutic environment.

Purpose: The purpose of this study was to investigate TC members' evaluations of Haigh's (2013) quintessence principles within the LDTC based at one of three high secure hospitals in the U.K.

Aims:

1. Explore service user and staff members' evaluations of TC principles as outlined by Haigh (2013) and identify whether these are present in the environment of the LDTC at a high secure hospital.
2. Identify whether any further important principles exist within the social climate of the LDTC that are not captured by current TC theory.

Method

Participants were recruited from one of three high secure hospitals in the U.K. within an LDTC.

Participants

Stage one: Six service users, all white, aged between 27-50 years with 2.5-5 years of residing in the LDTC. Six staff members, aged between 34-53 years, with 4-5 years of working in the LDTC.

Data collection

Stage one: Semi-structured interviews lasting between 30 minutes to 1.5 hours, focusing on evaluations of quintessence principles and additional experiences within the LDTC.

Analysis

Deductive content analysis was used to identify whether quintessence principles existed in the environment after which an inductive thematic analysis (TA) was employed on remaining data.

Results

All five quintessence principles were confirmed in the LDTC.

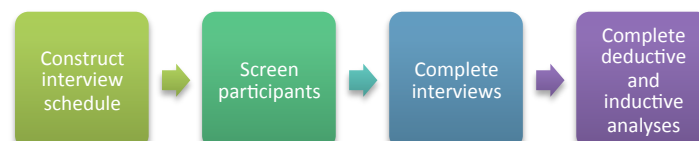
The inductive analysis identified four main themes that were important and recurrent (as highlighted via saliency analysis): more physical freedom, security and risk, responsivity and trust.



What we learned:

- While the quintessence principles are evident in the LDTC, there are limits to the principle of Agency – with specific regard to flattened hierarchy.
- Additional features are evident in the LDTC including trust, responsivity, and more physical freedom, which all appear to compliment implementation of quintessence principles within a high secure environment.

Design procedure – Qualitative single case study procedure



References:

Haigh, R. (2013). The quintessence of a therapeutic environment. *Therapeutic Communities*, 34(1), 6-15. DOI:10.1108/09641861311330464

Morrissey, C. & Taylor, J. (2014). Changes in personality disorder traits following 2 years of treatment in a secure therapeutic community milieu. *Journal of Mental Health Research in Intellectual Disabilities*, 7(4), 323-336.